

AN ABSTRACT OF THE THESIS OF

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Abstract approved:

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In this ethnographic study, I examine how women living in downstate Illinois decide to give birth at home. I view decision-making as a process that unfolds throughout pregnancy and continues into the postpartum period, contextualizing “choice” in a region where homebirth is a politically and socially marginalized practice. The methodology bases itself in modified grounded theory, bringing together initial survey research, in-depth, semi-structured interviews with 21 homebirth mothers, and two follow-up focus group discussions. I draw from and build upon insights in critical medical anthropology (CMA), feminist bioethics, and anthropological theories of embodiment. Findings reveal that women decision-making processes center around three, chronologically ordered themes. First, when women make the initial decision to birth at home, they directly reflect upon past birth experiences (their own and/or those of close family and friends). This period of reflection leads women to articulate critiques of the technocratic model of birth as well as to voice a common desire for

shared decision-making during pregnancy and labor. Second, as women seek they often face social and economic barriers in the process, especially in regions without a licensed provider. Nonetheless, homebirth mothers desire and actively work toward combining care from both homebirth providers and the formal biomedical system. Finally, after the birth, women talk with others about the existence and benefits of homebirth in the hopes of generating a greater awareness and acceptance of multiple models of maternity care. Recommendations from this study include a restructuring of the dominant political discourse surrounding homebirth away from a debate over biomedical notions of risk. Instead, I advocate for re-framing the debate by echoing Bridgette Jordan's call for mutual accommodation (1978) between birthing models as way of understanding and negotiating multiple ways of defining what it means to have a “safe delivery.” I conclude by emphasizing the need for a debate that puts the diverse voices and needs of birthing women at its center with the ultimate goal of creating a maternity care system that serves the interests of more mothers and babies.

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The Political Economy of Birth Choice: Mothers' Experiences Seeking Homebirth
Care in a Felonious State

by
Grace C. Grinager

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I understand that my thesis will become part of the permanent collection of Oregon State University libraries. My signature below authorizes release of my thesis to any reader upon request.

Grace C. Grinager, Author

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**The Political Economy of Birth Choice: Mothers' Experiences Seeking
Homebirth Care in a Felonious State
Chapter One: Introduction**

Reproduction...provides a terrain for imagining new cultural futures and transformations through personal struggle, generational mobility, social movements, and the contested claims of powerful religious and political ideologies. These imaginings and actions are often the subject of conflict, for they engage the deepest aspirations and the sense of survival of groups divided by differences in generation, ethnicity, race, nationality, class, and of course gender. (Ginsburg and Rapp 1995, 2)

This study examines U.S. women's experiences seeking homebirth care in a state where out-of-hospital (OOH) births attended by direct-entry midwives (DEMs) are felonies. It does so through listening to the stories of mothers who have given birth at home. Recognizing the integral role of the stories we tell each other, the stories we hear, and the stories we tell ourselves in knowing about birth in this and other cultures, I hope that readers will listen to the collective voice of the women I interviewed. Listening to birthing women provides a powerful impetus to reflect upon systems of maternity care, as they exist both in formalized policies and in the lives of those whose health they ultimately affect.

In this thesis, I examine how women who live in a state where homebirth midwifery is often not a legal option, make the decision to birth at home. By eliciting the birthing narratives of homebirth mothers in downstate Illinois and analyzing them within the cultural and political context of OOH midwifery regulations in the state, I seek to explain how health policies that restrict birthing options are understood and negotiated by women on the ground. Listening to the experiences of women who have

chosen to give birth at home in this context provides a complex picture of how and why they have made this decision; this perspective, I argue, is imperative to understand for anyone who is concerned with improving the health of birthing women in the region.

The relationship between the legal status of midwifery and the health of birthing women merits a short discussion here, especially as it pertains to homebirth in the United States. Throughout the U.S., it is legal for a woman to give birth at home, though state policies dictate who can legally attend a woman in labor. In the United States there are two types of midwives, Certified Nurse Midwives (CNMs) and Direct-Entry Midwives (DEMs) (Cheyney 2008, Davis-Floyd 1998). CNMs train first as nurses, then as midwives. They can legally practice in all 50 states; most often they do so in hospitals. Regardless of where they practice, they must always do so under the supervision of a physician. DEMs bypass nursing school and go directly into midwifery training. Their educational routes vary, but usually include some combination of apprenticeship and formal online or site-based learning. Licensure regulations for DEMs vary by state, although there is an internationally recognized certification they can apply for, leading to the title of Certified Professional Midwife (CPM). DEMs are the type of midwife that most commonly attends homebirths (Cheyney 2008, Davis-Floyd 1998).

Ultimately, each state has the authority to set its own regulations surrounding midwifery care. Not all states recognize the CPM certification, and some do not allow

any type of DEM to legally practice. At present, there are 27 states where it is legal for DEMs to practice, and 23 states where DEMs are not legally recognized as providers (The Big Push for Midwives 2010). When a state does not legally recognize homebirth midwives, such policies make it more difficult for a homebirth mother to locate a provider, to receive any type of insurance reimbursement for her maternity care, and to file a birth certificate (Cheyney 2005). In Illinois, not only are CPMs not legally recognized by the state, but also state law considers all types of DEMs (CPMs included) to be practicing medicine without a license (per 225 ILCS 65/20-75a). Many providers have left the state due to legal entanglements, especially after the mid-1990s when the Illinois Department of Professional Regulation (IDPR) started to issue cease and desist orders to midwives throughout the state of Illinois (Personal communication, Coalition for Illinois Midwifery).

Legal restrictions on homebirth midwifery in Illinois are a major disincentive to aspiring midwives who want to practice their profession legally. While CNMs are legally able to practice, they must have a formal relationship with a back-up physician in order to attend women who deliver at home. Often CNMs cannot find a willing collaborator, and so they are also often unable to practice legally outside of the hospitals. In light of the unique legal situation in Illinois, in the non-Chicago metropolitan portions of the state, there are very few midwives who are legally able to attend births at home; only 6 of the state's 102 counties have legally practicing homebirth providers (Personal Communication, Coalition for Illinois Midwifery).

Illinois is a unique state because it has an incredibly concentrated area of economic resources, population density, and state-level political representation in the Chicago metropolitan area. The use of the emic term, “downstate,” reflects a common sentiment expressed throughout interviews – that is, that the state is divided into two areas—Chicago and “everywhere else.” While Chicago acts as the population and economic hub, the state itself is geographically quite expansive with much of the state comprised of rural, agricultural land. For the purposes of this study, I collected data in two primary sites. While the two sites in this study are similar in that they are both outside of the state's center of political power, there are marked differences between them. In the Central site, there are two CNMs who can legally attend homebirth, whereas in the Southern site there are no legal providers. In general, this created a marked difference in how openly women talked about their birth experiences, the difficulties they faced in locating a provider, the potential for insurance reimbursement, and the ease with which women were able to coordinate care with hospitals and physicians.

The decision-making processes for women who birth at home in the United States take place within a wider political-economic environment where homebirth is a controversial topic. The American Association of Public Health (2001), the World Health Organization (1996), The American College of Nurse Midwives (2005), and the Midwives Alliance of North America (2010) have all voiced their support of homebirth by advocating for midwifery care as a cost-effective, safe option for low-

risk women with the potential to meet the needs of birthing women throughout the country. At the same time, the American Medical Association (2008) and the American College of Obstetricians and Gynecologists (2007) strongly oppose OOH birth, which occurs either in the home or in a birth center that operates independently of a hospital, citing safety concerns over the practice.

In the midst of this macro-level debate over the relative safety of homebirth, a small but growing number of women continue to choose to give birth at home (MacDorman, Menacker, & Declercq 2010). When I say that a woman “chooses” to have her baby at home, I consider choice to be a process rather than a singular event. “Choice,” becomes a series of decisions that unfold throughout childbearing. They involve her personal motivations, her family, her care provider, her economic resources, and her social universe. By eliciting women's birth narratives, I aim to capture the complexity of homebirth women's decision-making processes as they themselves describe them.

In her article, “Homebirth as Systems-Challenging Praxis,” Cheyney (2008) examined how women choose to have a homebirth, and the processes that unfold after a woman makes that initial decision. She found that women reaffirm their choice throughout pregnancy by developing empowering ways of explaining and knowing about birth, supported by close relationships with midwives. Cheyney's study is unique in that, to date, ethnographers studying homebirth in North America have often focused on the way in which women create meaning out of their birth experience,

without looking more concretely at how specific choices are made and reaffirmed throughout the pregnancy and birth (Klassen 2001, MacDonald 2006). Studies of homebirth in North America do not often focus on linking individual birth narratives to the policies that inform the political-economic context in which women make decisions (see Cheyney 2010, Davis-Floyd 2006 for exceptions). However, studies of birth in most other parts of the world tend to contextualize individual-level decisions and experiences surrounding birth within wider maternity care systems and the political-economic constraints that shape them.

In many resource-scarce areas of the world, birthing at home is the norm rather than the exception. While the birthing experiences of women worldwide are embedded within a diversity of culturally informed health systems, common themes emerge from this body of work. Factors that are repeatedly shown to influence a woman's decision-making regarding where and how to deliver include: the local reputation of hospitals, difficulties transporting to the hospital during labor, financial constraints in accessing hospital services, spiritual beliefs surrounding pregnancy, a disconnect between social and biomedical knowledge, and the selective use of biomedically informed practices during labor (Adams et al. 2005, Berry 2006, Donner 2003, Jenkins 2003, Kyomunhendo 2003).

My research aims to connect rich, individual-level birthing narratives so often present in ethnographies of homebirth in North America to the more contextualized approaches present in the literature on choices in childbirth globally. By combining

the strengths of these two ethnographic bodies of literature, I will locate the effects of state and federal legislation and policy debates within the holistic contexts of women's lived, reproductive experiences and decision-making processes, focusing specifically on the homebirth community. By bringing these two bodies of literature together in a state-specific, regional study of how women choose their birth place, it becomes possible to locate the effects of health policies on a woman's choices as they describe them.

This research responds to the call for an understanding of the social and political contexts within which women make reproductive choices (Beckett 2005, Rapp 2001). It also responds to the call for research that seeks to understand how health policy is lived and negotiated by individuals in their daily lives (Horton and Lamphere 2006, Jenkins 2003). I pay close attention to the ways birthing women attempt to articulate a system of mutual accommodation as they seek homebirth care, even as powerful systems of authoritative knowledge (manifest in individual attitudes, hospital policies, the practices of health insurance companies, and in state law) maintain an enormous amount of power over whether to allow such a system to emerge.

This study combines basic demographic survey data (Phase I) with in-depth, semi-structured interviews (Phase II) and focus group discussions (Phase III) and intermittent participant observation at childbirth education classes, breastfeeding support groups, natural parenting groups, online homebirth communities, a locally produced play on birth in America, and at the state capitol. I analyze all data using the

methodological tools of grounded theory (Charmaz 2006).

In the pages that follow, I begin with a review of the relevant literature surrounding homebirth (Chapter Two). In Chapter Three, I move into a discussion of the theoretical perspectives that inspire and guide my analysis, notably the areas of critical medical anthropology (CMA), anthropological theories of embodiment, and feminist bioethics. Chapter Four describes the methodological framework that guides my fieldwork and subsequent analysis. Chapter Five examines the key themes that emerged in this research: 1) reflecting on past birth experiences, 2) seeking care, and 3) advocating for change. Chapter Six is an analysis of these themes as they relate to the pre-existing theories described in Chapter Three.

Collectively, the stories of homebirth mothers in this study illustrate a reality that is not captured in the safety debate that currently dominates the discourse on whether to integrate homebirth into our health care system through legislative change. In order to support mothers who are already working toward mutual accommodation as they make decisions about their own births, the terms of the debate need to shift toward birthing women's priorities. Mothers who participated in this study expressed the desire for: 1) a greater availability of legally practicing midwives, 2) increasing awareness among the general public and health care providers that homebirth is a viable and safe option for low-risk women, and 3) the right to decide for themselves how, where, and with whom to give birth. Based on these findings, I conclude by revisiting Jordan's (1978) call for mutual accommodation between different models of

birth. I advocate listening to mothers as a foundational first step in creating a more integrated system of maternity care in Illinois and throughout North America.

Chapter Two: Literature Review

I begin this chapter by looking at the way in which homebirth is most often discussed and studied in debates in the United States, centering on concerns of risk and safety. I consider this phenomenon alongside relevant literature on the concept of authoritative knowledge, birthing paradigms, and the ways in which individuals create alternative notions of risk and safety as they make health-related decisions. Next, I compare ethnographic studies of homebirth in the United States to analogous studies on place of delivery in low-income nations around the world. I argue that because in many other parts of the world birth at home is the norm rather than the exception, these studies often have a more contextualized approach relative to those based in high-income nations where the focus tends to be on individual values and rights.

By bringing together relevant studies on authoritative knowledge, birth paradigms, critical decision-making in health, and ethnographic studies of birthplace, I hope to create a new vocabulary for thinking and talking about homebirth in the U.S. In an illegal context such as Illinois, where the discussion of birthing options overwhelmingly focuses on biomedical notions of risk, it is important to recognize how and why birthing women's decisions transcend the boundaries of a dichotomous safety debate. Not only are women's decisions deeply informed by relevant values and experiences, but also they are intimately connected to the political and economic realities of her world. Such an understanding is well positioned to form the basis of a maternity care system that is truly sensitive to the needs of women.

(Re)Framing the Homebirth Debate in the United States: Decision-Making, Risk, and Authoritative Knowledge

The debate over homebirth in the United States overwhelmingly focuses on the safety of the practice itself. Evidence of the ideological divide that underlies the safety issue exists in the position statements on homebirth that professional organizations associated with childbearing circulate. For example, the American Medical Association (AMA) (2008) and the American College of Obstetricians and Gynecologists (ACOG) (2008) state:

The American College of Obstetricians and Gynecologists (ACOG) reiterates its long-standing opposition to home births. While childbirth is a normal physiologic process that most women experience without problems, monitoring of both the woman and the fetus during labor and delivery in a hospital or accredited birthing center is essential because complications can arise with little or no warning even among women with low-risk pregnancies...Childbirth decisions should not be dictated or influenced by what's fashionable, trendy, or the latest cause célèbre. Despite the rosy picture painted by home birth advocates, a seemingly normal labor and delivery can quickly become life-threatening for both the mother and baby.

Conversely, organizations such as the American Public Health Association (APHA)(2001), the Midwives Alliance of North America (MANA)(2010), the World Health Organization (WHO)(1996), and the American College of Nurse Midwives (ACNM)(2005) argue that homebirth midwifery care is a safe option for low-risk women. For example, ACNM (2005) states:

The safety of birth in any setting is of utmost priority

and has been the focus of home birth research. Investigators have defined “planned home birth” as the care of selected pregnant women by qualified providers within a system that provides for hospitalization when necessary. Recently, high quality controlled trials and descriptive studies have established that planned home births achieve excellent perinatal outcomes. Home birth is also credited with the reduced use of medical interventions that are associated with perinatal morbidity.

The debate over whether homebirth is safe is not limited to the position papers of professional organizations. It also appears as a focal point in state-level attempts to pass legislation surrounding midwifery care. At the time of this writing, the Coalition for Illinois Midwifery (CFIM) is involved in an effort to pass a bill that would recognize the Certified Professional Midwife (CPM) credential. This move would change the status of CPMs from felons who could be charged with practicing medicine without a license to legally recognized birth-providers allowed to carry oxygen and anti-hemorrhagic drugs. This effort forms part of what has been a thirty-year long struggle to change midwifery legislation the state of Illinois. Even the name of the bill is evidence of the perennial concern with safety; it is called The Homebirth Safety Act (SB3712).

In her study of the decline of African American Midwifery in the state of Virginia, ethno-historian Gertrude Fraser (1998) found that the rhetoric of safety was used to create a licensure system that systematically debased midwives as maternity care providers starting in the early 1900s and continuing on into the 1940s. Fraser links this rhetoric to a regional government agenda that aimed to increase its control

and regulation of pregnant women, while using racial stereotypes to marginalize the experiential knowledge of midwives, who were overwhelmingly African-American.

It seems ironic that grassroots advocacy groups in Illinois are pushing for licensure of midwives when Fraser has shown that, at least in the case of Virginia, government licensure was the very means by which early twentieth century midwives lost their autonomy as providers. This conundrum around power, autonomy, and licensure helps to explain why the idea of safety has remained central to midwifery debates in the United States for over one hundred years. It brings our attention to the fact that the question at hand isn't *really* whether homebirth is safe—at this point, ample evidence exists to support that it is (see for example, Janssen PA, Lee SK, Ryan EM, Etches DJ, Farquharson DF, Peacock D, et al. 2002; Johnson and Daviss 2005; Olsen O 1997; Rooks JP 1997). Rather, the question is more about *who* gets to decide what is safe and what the implications of that decision are for shaping a system of care for birthing women.

Authoritative Knowledge

An important contribution to understanding both the importance and the longevity of the safety debate come from anthropologist Brigitte Jordan. In 1978, Jordan published a comparative study called *Birth in Four Cultures: A Cross-cultural Investigation of Childbirth in Yucatan, Holland, Sweden, and the United States*, which has since become a classic in cultural studies of pregnancy and birth. This work spurred a flurry of academic interest in studying the rituals and beliefs surrounding

birth around the world. Aside from detailed ethnographically based descriptions of birth in each setting, Jordan uses her observations to create a theory of authoritative knowledge which she builds on in her later work (1997).

At its core, “the power of authoritative knowledge is not that it is correct but that it counts” (Jordan 1997, 58). To begin to understand what she means by this, Jordan explains that in any given social situation, there are multiple systems of knowledge, or ways of knowing about any given topic. While it is possible for multiple ways of knowing to peacefully co-exist, most often one gains prominence at the expense of the other. This may be because one way of knowing is better at explaining the world, or it could be because it is linked with she calls, “structural superiority” (56), an association with more powerful segments of society. Regardless of the reason, an inherent feature of authoritative knowledge is that it renders all other ways of knowing illegitimate. She says of those who continue to adhere to non-authoritative knowledge: “whatever they might think they have to say about the issues up for negotiation is judged irrelevant, unfounded, and not to the point” (56).

If we look at the safety debate surrounding midwifery in the United States, authoritative knowledge can be seen as guiding the position that homebirth is unsafe, as this is the way of thinking that has set the terms of the debate. In a country where 99% of all births occur in the hospital, the idea that our culture sees the hospital as the appropriate place to give birth hardly comes as a surprise. But where does this leave advocates of homebirth midwifery? Speaking from outside the realm of authoritative

views on birth in North America, the view that homebirth *can* be a safe option is easily disregarded. Consider the position statements at the beginning of this section. While ACNM cites the results of multiple safety studies to support their position, ACOG instead focuses its message on the magnitude of risk inherent in birth itself. Citing studies appears as an act in defense of safety that *responds to* the way in which ACOG invokes the authoritative knowledge that birth is an inherently risky, and therefore dangerous, process. Risk in birth is the default setting, but safety must be demonstrated.

The continuing dissonance between these positions over time indicates that authoritative knowledge is not an object to be had, but an ongoing process to be negotiated between social actors. The idea that birth is dangerous would not be prominent if it were not for a general consensus that is created and recreated by birthing women and their providers, the mainstream medical system, and the way birth is most often portrayed in the media. Conversely, while it may not be authoritative in U.S. society at large, the idea of homebirth as safe is also created and recreated by a minority group of women and their providers. Aside from citing the more than 30 studies that have shown that midwifery care results in lower rates of intervention and improved outcomes for mothers and babies (Cheyney 2010, 4), advocates of homebirth midwifery also use personal stories and experiences to create a shared view of birth as a normal life event, rather than a clinical pathology.

Jordan (1997) explains that the process by which authoritative knowledge comes

to be both creates and reflects systems of power, while acting as a way of naturalizing the status quo. In the example of childbirth in America, hospital birth is authoritative in that it has come to be considered the only legitimate option for birthing women in the collective consciousness of the majority of Americans—even if people do not necessarily acknowledge that they may be adhering to a particular system of knowledge when they decide to have their babies in the hospital.

Jordan urges those involved in investigating birth to use the concept of authoritative knowledge as an invitation to uncover the social processes involved in knowing about and making decisions surrounding reproduction. Seeing change in birthing systems around the world as inevitable, in her early work (1978) she calls for mutual accommodation between different models of birth. In other words, she advocates multiple systems of birth co-existing and supporting one another—even if the systems operate under diverse belief systems. Whereas the current debate on homebirth in the United States focuses the question of whether it is safe to deliver a baby at home, an approach based on mutual accommodation would ask questions along the lines of, “given that a percentage of women deliver their children at home, how can we integrate home and hospital practice in a way that supports the practices of both doctors and midwives?” It is a solutions-driven approach that recognizes multiple birthing choices as inevitable. What is not clear from Jordan’s call for mutual accommodation is how power differentials around authoritative knowledge can be overcome to create a collaborative model of care. If a key feature of authoritative

knowledge is that it discredits other viewpoints, then how can different systems be integrated? How can providers accept or accommodate aspects of alternative models of care?

Birth Paradigms

Jordan is not the only anthropologist to have studied different ways of knowing about birth. Davis-Floyd (2001) has delineated the features of three different birth paradigms—the technocratic, humanistic, and holistic. The first, the technocratic model, is based on the Cartesian mind-body separation, as well as on what she calls the, “technocratic imperative,” the idea that technology can and will liberate us from nature. The second, the humanistic model, is based on human compassion. While this model still holds to the core tenets of biomedicine, it does so while recognizing the importance of bio-psycho-social factors. The third, the holistic paradigm, is based on the inseparable nature of the mind, body, and spirit. Cheyney (2010) elaborates on the differences between what she calls the medical/technocratic and the midwifery/holistic models, emphasizing that while the former sees the mother and baby as separate with potentially antagonistic needs, the latter sees the mother and baby as an inseparable unit.

Both Davis-Floyd and Cheyney note the limits to understanding birth simply through one of the aforementioned paradigms, stressing that providers tend to borrow and use elements of different models in their daily practices. They advocate these models as conceptual tools that can be used to find common ground between different

ways of understanding birth.

Critical Perspectives on Decision-Making in Health

One way of taking the debate over safety and risk out of the realm of professional organizations' viewpoints and broad-based descriptions of birthing models involves examining the decision-making processes of pregnant women themselves. To this end, I have reviewed current literature that adopts a critical stance toward understanding decision-making in health. By critical, I mean that all these studies (Browner and Preloran 1996, Browner and Preloran 2004, Cheyney 2008, Horlick-Jones and Prades 2009, Mykhaloskiy 2008, Possamai-Inesedy 2006, Rapp 2000, Root and Browner 2001, Seear 2009, Spencer-Freeze 2008, Thompson 2008, and Viisainen 2000) share a commitment toward locating the decisions individuals make within a holistic context. In doing this, they also reject the mainstream notion of people as rational-actors who will act according to biomedical recommendations if they are given the information they need to make choices. While the topics under study range from industrial pollution, to prenatal care, to clinical noncompliance among those living with chronic illness, the way in which these articles show how individuals respond to notions of safety and risk in their decisions can be used to better understand how women choose to birth at home in a state where homebirth is not seen as a legitimate choice.

Several studies show the diverse ways in which individuals balance knowledge gleaned from their own embodied experiences with authoritative ways of knowing as

they make decisions about their health (Browner and Preloran 1996, Browner and Preloran 2004, Mykhaloskiy 2008, Root and Browner 2001). In a study of women's experiences of prenatal care in a variety of clinics in California, Browner and Preloran (1996) show that women use their own bodily experiences as a check to biomedical recommendations. If their lived experience does not support the advice of their care providers, such advice tends to be disregarded. The only exception they found was that women tended to unequivocally accept recommendations to receive technological tests in the prenatal period, an exception that the authors believe to be rooted in a deep cultural trust in technology.

In later studies on prenatal care and testing (Browner and Preloran 2004, Root and Browner 2001), researchers focus on the role of patient and provider expectations in shaping patients' compliance or non-compliance with recommendations. When patients feel like their expectations have not been met after a clinic visit, they afford less importance to the provider's subsequent advice.

Mykhaloskiy (2008) situates decision-making at the locus of bodily experience and biomedical discourse in the lives of people living with HIV/AIDS as they decide whether to undertake antiretroviral treatment. He shows that patients from lower socioeconomic classes often disregard biomedical recommendations because they are often difficult to understand and rarely reflect what he calls the “daily healthwork” (151) of life in poverty. This type of “healthwork” relies heavily on sharing information amongst peers through comparing one another's experiences with various

illnesses and treatments.

In contrast to the notion that risk is a static entity, recent ethnographic research regards the idea of risk in human health as a socially constructed phenomenon (Horlick-Jones and Prades 2009, Possamai-Inesedy 2006, Spencer-Freeze 2008, Browner and Preloran 2004, Mykhaloskiy 2008, Rapp 2000, Spencer-Freeze 2008). Many studies examine the ways in which socioeconomic class and ethnicity affect one's perception of risk and consequent actions (Horlick-Jones and Prades 2009, Mykhaloskiy 2008, Rapp 2000). Others examine the ways in which individuals talk about and think about risk in relation to expert definitions (Horlick-Jones and Prades 2009, Possamai-Inesedy 2006, Rapp 2000, Spencer-Freeze 2008).

A study by Horlick-Jones and Prades (2009) looks at the dissonance between expert and lay perceptions of risk in a case study of industrial pollution at various sites throughout Europe. Throughout the diversity of geographic locations, investigators found that a number of patterns emerged. First, they found that people frame risk in a much more comprehensive way than do technical accounts. This includes separating acute risks (such as a chemical spill) from chronic risks (such as asthma). Second, notions of risk reflect one's personal life circumstances and lived experience. Third, they find that other relevant local issues influence the extent to which an individual sees industrial pollution as a risk.

Spencer-Freeze (2008) discusses the ways women who choose unassisted childbirth (UC) in the United States approach issues of safety and risk. While she

finds that many women would like to see statistically-based safety studies, women who choose UC do so because they see it as the best way to facilitate the natural physiological process of birth by minimizing the amount of interference from outsiders. She finds that an important way that women who decide to birth unassisted mitigate risk is by learning how to recognize and transfer care in the event of an emergency.

A number of articles have looked at ways in which decision-making can be a form of resistance to authoritative forms of biomedical knowledge (Cheyney 2008, Root and Browner 2001, Seear 2009, Thompson 2008, Viisainen 2000). Cheyney (2008), for example, explains that when women decide to have a homebirth in the United States, they are directly challenging the notion of birth as something that should be performed by physicians in a hospital setting. Thompson offers another way of looking at natural birth as cultural critique. He argues (drawing from the work of Giddens 1991) that in a world where systemic risks—those that cannot be mitigated by individuals alone—abound, there emerges a strong network of governing bodies (i.e., governments, scientists, corporate review boards). We are expected to trust such bodies. However, such trust can easily come under question when it is not maintained through personal experience. He uses the natural birth community in North America as an example of a community of what he calls “reflexive doubt.” Through personal experiences and shared alternative narratives, members of this community come to see the risks associated with unnecessary interventions as the risks that are most important

(for a similar interpretation of risk perception in homebirth, see Viisainen 2000).

In line with this idea of reflexive doubt are studies that consider how noncompliance can alternatively be read as an act of resistance. In her study of women living with endometriosis, Seear (2009) shows that non-compliant women were advised by physicians to consider potential treatments that did not account for the multiplicity of exigencies found in women's daily lives and priorities. Many women questioned the knowledge and authority upon which their physicians made recommendations. She concludes that noncompliance should act as an impetus for researchers to turn the medical gaze away from the patient and toward the context in which providers make recommendations.

Together these ethnographic studies of decision-making in health care provide a framework that allows us to better understand how women make decisions surrounding pregnancy and childbirth. However, all of these studies took place in high-income nations. I turn now to a review of cross-cultural studies on birthplace which examine women's decision-making in diverse locales around the world.

Birth Places: Ethnographic Studies from Home and Abroad

Despite the fact that most births in high-income nations occur in hospitals, a growing body of literature examines the various reasons why a minority of women in these countries chooses to birth at home. These studies tend to portray birth as a deeply personal process in a woman's life, and one that birthing women should maintain control over (Klassen 2001, MacDonald 2006). The revival of interest in

birth at home in the global north is commonly tied to a woman's desire to birth without unnecessary technological intervention in a comfortable and private environment in which she feels in control. Such desires are often strongly tied to a woman's trust in her intuition and her body's ability to birth (Boucher 2009; Cheyney 2008; Janssen, Henderson, and Vedam 2009; Lingred, Hildingsson, and Radestad 2006; and Viisainen 2001). Another common theme is the importance of having a skilled attendant present, specifically someone with whom the birthing woman has built a relationship of trust (Cheyney 2008, 2010; Dahlen, Barclay, and Homer 2010; Janssen, Henderson, and Vedam 2009; Lindgred, Hildingsson, and Radestad 2006; Viisainen 2001).

While the aforementioned studies overwhelmingly focus on the individual as a level of analysis, ethnographic accounts of childbirth in low-income nations generally focus their analyses on a combination of cultural beliefs and practices surrounding birth and pregnancy, experiences and views of hospitals, as well as on the economic constraints of daily life (Adams et al. 2005; Berry 2006; Donner 2003; Hunter 2002; Jenkins 2003; Kyomuhendo 2003; Maklouf Obermeyer 2000; Otis and Brett 2008; VanHollen 2003). Common themes from this body of research include the reputation of local hospitals, difficulties transporting oneself to the hospital during labor, financial constraints in accessing hospital services, spiritual beliefs surrounding maternity care, and the selective use of biomedically-informed practices during labor.

Not all women living in low-income nations choose to birth at home with midwives. Some women in developing countries seek hospital birth as a status

symbol (Donner H., 2003; Hunter CL. 2002; Jenkins GL., 2003; Makhoul Obermeyer C., 2000; Van Hollen C., 2003). For these women, biomedicine is not a monolithic force that marginalizes traditional practices. Rather, it is seen as an opportunity to access services that have historically not been available, services that may increase a birthing woman's safety and comfort while acting as a marker of social status within one's community. On the other hand, similar studies show that in certain parts of the world (Adams V. et al., 2005; Berry N., 2006; Kyomuhendo GB., 2003; Makhoul Obermeyer C., 2000; Otis KE, Brett JA., 2008; Van Hollen C., 2003) many birthing women actively avoid hospitals during pregnancy and birth. Women cite the fear of being alone, discriminated against, or surrounded by strangers as a deterrent to seeking hospital services.

Discrimination can take the form of miscommunication between birthing women and their providers (Adams V. et al., 2005), not being attended during labor (Otis KE., Brett JA. 2008; Van Hollen C., 2003), harsh verbal treatment in the medical facility (Adams et al., 2005), physical slaps and beatings (Van Hollen C., 2003), or forced hospitalization and displacement from one's community during birth (Kaufert PA., O'Neil 1990; Kornelsen et al. 2010). In most cases, these types of discrimination act as deterrents to seeking hospital birth. However, in her ethnographic account of birth in South India, Van Hollen (2003) found that women in the public maternity wards of Tamil Nadu responded to verbal abuse and threats of violence in diverse ways. While most women recounted these acts with a mixture of ambivalence and

anger, some accepted them as helpful and even necessary:

Threats to beat women who made too much noise did not in fact always materialize and were sometimes viewed more as maternal gestures of discipline which were intended to tease rather than torment. These were viewed as *maternal* gestures since obstetricians were almost always women. Even when they were beaten, women sometimes experienced it as a form of caring. (133).

Such findings underscore the importance of contextualizing a woman's experience of and choices in birth within a larger cultural context.

Even if women want to birth in the hospital, a lack of financial resources (Adams V. et al., 2005; Hunter CL. 2002; Jenkins GL., 2003; Kyomuhendo GB., 2003; Makhoulf Obermeyer C., 2000; Otis KE, Brett JA., 2008; Van Hollen C., 2003) may prevent her from traveling to the hospital or paying for clinical services upon arrival, even in the case of an obstetric emergency. The infrastructure (roads, transportation systems, etc.) in many rural areas make transport a lengthy, and at times, an impossible endeavor (Adams V. et al., 2005; Jenkins GL., 2003; Kyomuhendo GB., 2003; Otis KE, Brett JA., 2008). Poverty is a major constraining factor as even women who desperately need obstetric care cannot necessarily reach hospital facilities for delivery complications.

Even if a woman is able to access a hospital, there is no guarantee that the hospital itself will be able to provide the obstetric services that she needs. In low-income nations, lack of resources is a common theme not only among birthing women, but also among the hospitals that are available to serve them. Despite the lofty, and

often laudable, goals of international health professionals, many of the governments of these countries have limited financial resources themselves. In a study of risk perception among rural birthing Tibetan women, Adams et al. (2005) sums up the ways in which a lack of hospital resources can affect a woman's choice to seek obstetric care in a hospital:

Even in those hospitals that had personnel who were trained in emergency services, few providers in these settings had the ability to perform these services because they lacked medical equipment and supplies to do so. This greatly undermined villagers' confidence in the government-provided clinical services (833).

Aside from the logistical and economic factors that limit where and how a woman gives birth, there are important socially-constructed spiritual beliefs that inform decisions surrounding childbirth. Associations between childbirth and pollution in South Asia, for example, shape Tibetan women's decisions to birth alone in the barn or other areas outside of the house (Adams V. et al., 2005). They also affect middle and upper class Indian women's decisions to opt for hospital births (Donner H., 2003; Hunter CL. 2002; Van Hollen C., 2003). Demons, spirits, and witchcraft are thought to cause birth complications in a variety of settings. This can lead people to hide their pregnancies and labor (Adams V. et al., 2005) or to seek the aid of a traditional healer for obstetric conditions (Berry N., 2006; Jenkins GL., 2003; Van Hollen C., 2003).

The differences between birthing paradigms are blurred as women negotiate and selectively use the tools of both biomedicine and traditional healing that are at

their disposal in low-income nations. The results of these negotiations are not always what one would expect. For example, in Tamil Nadu, labor is thought to be progressing normally if pain, *vali*, is strong and regular. Prolonged labor is associated with both maternal and infant death and morbidity in people's memories. *Vali* is linked to notions of female strength in labor. Thus, to appear strong and to avoid the perceived risk of complications, women very often want their labors to be induced in the hospital with oxytocin drugs (epidocin and sintocin), but without analgesics. This practice carries over into the community that gives birth at home. The use of oxytocin drugs at home is as prevalent as it is in the hospital, highlighting the role that women themselves play in the prevalence of artificially induced labor. In fact, many women have come to see these drugs as a “right” or essential. The trouble arises, Van Hollen argues, from the fact that these drugs carry with them very real side effects (from interfering with blood flow to the fetus to uterine rupture). In addition, the women administering them often do not have the training to understand the risks involved, nor do they have the means to transport women to the hospital in the case of an obstetric emergency resulting from induction (13). Accounts like this highlight the importance of Brigitte Jordan's call for mutual accommodation as way to meet the diverse needs of birthing women rather than adhering to any particular preconceived view of what birth is and, consequently, should be.

The authors cited in this section note that there is a profound divide between the local realities of birthing women and the broader political rhetoric and policies that

affect them. The experiences of birthing women and the changes they would like to see in order to improve maternal and child health are highly situational. Jenkins (2003) sums up the need for contextualized, ethnographic work as the basis for future health programs and policies this way:

Combining a top-down and bottom-up perspective generates a more complex, dynamic, contextualized understanding of how local-level actors strategize to create maternal-child health. In the final analysis, the local level is the most important for understanding health change: policies and programs are utterly ineffectual unless local level actors decide to take action. This important perspective illuminates the socio-legal and political context for local change, exposing the effects of international programs and national policies on the local level. But we must also view these questions from the bottom-up, an analytical angle that offers important opportunities to understand the agency of rural women as it articulates with national and international policy (1907).

Many of these articles end with suggestions for either policy change or potential health intervention programs, and many more offer criticism of current efforts that aim to improve maternal and infant health. The overarching message of the articles in this section is that the disconnect between social and biomedical knowledge surrounding maternal health is not absolute; as Locke and Kaufert (Eds. 1998) also have shown, around the world women pragmatically negotiate alternate systems of healing during pregnancy and birth, selectively using biomedical practices and technologies as they see fit.

This literature review attempts to combine relevant studies on authoritative

knowledge, birthing paradigms, decision-making in health, and birthplace in low-income nations in order to create a new lens through which to conceptualize homebirth in an illegal context in the United States. Rather than focusing on the dichotomous safety debate that dominates current discourse surrounding homebirth in this context, these bodies of literature can provide a means by which to understand the decision to birth at home in a more nuanced, woman-centered manner. Such a perspective is imperative for anyone who is truly concerned with creating a maternity care system that truly centers itself on the needs of mothers and babies.

Chapter Three: Theoretical Framework

In order to examine how women decide to give birth at home, as well as how their choices relate to wider political discourses on birth, I situate my analysis within the theoretical framework of critical medical anthropology (CMA), anthropological theories of the body and human reproduction, and the field of feminist bioethics. Together these perspectives allow for a nuanced understanding of health-related decision-making processes that take into account the unique, gendered identities and political-economic realities of individuals.

Critical Medical Anthropology

Critical medical anthropology (CMA) is an approach in medical anthropology that is explicitly committed to creating a more just and equitable health care system through researching, understanding, and changing the complex relationships between health outcomes and the wider political economic context where they are embedded. Pioneered by the work of Merrill Singer (1995), this approach argues that power should be central to any study of human health. In his early article (1995), “Beyond the Ivory Tower: Critical Praxis in Medical Anthropology,” he lays out the core tenets of CMA. He begins by stressing the inherently political nature of health, placing power at the center of CMA's research agenda. He goes on to relate differential health statuses to widespread social inequalities in access to basic resources (food, shelter, etc.) necessary for human well-being. He argues that individuals and local communities cannot be separated from larger political-economic systems, and

therefore, that researchers should focus on the role of power as it differentially exists and shapes experiences of illness.

Singer and Baer (1995) combine these tenets together as they explain the overarching goal of CMA. They state (1995:61) that its mission “is emancipatory; it aims not simply to understand but to change culturally inappropriate, oppressive, and exploitive patterns in the health arena and beyond.” With this mission in mind, Singer (1995) differentiates between what he terms “systems-challenging” and “systems-correcting” practice. Systems-challenging practices directly confront the root causes of inequality in health outcomes, while systems-correcting practices merely address the symptoms of deeper social issues (such as unequal wealth distribution and racism). He calls for collaboration between academics, activists, and marginalized groups as one way to achieve the type of social change that characterizes systems-challenging work.

After describing the core tenets of CMA and differentiating between “systems-challenging” and “systems correcting” practice, Singer (1995) offers concrete ways that CMA can help to change oppressive systems of health. First, he wants academics to collaborate with marginalized groups to help them attain a greater degree of self-determination. Secondly, he wants to increase awareness of the social and ideological dimensions of health and medical concepts. And finally, he seeks to link local realities with global systems in order to reveal and ultimately transform, “the structural roots of suffering and ill health” (1995: 99).

While Singer's work does not stand alone in the field of CMA (Baer, Singer, and Susser 2003; Farmer 2004; Pfeiffer and Nichter 2008; Scheper-Hughes 1990), his 1995 article succinctly lays a theoretical foundation upon which the discipline has grown. The strength of this approach is that it forces researchers to attune themselves closely to the role of political-economic power as it manifests itself in multiple levels of analyses. Thus, CMA acts as a roadmap for anthropologists as they create a research agenda focused on power and health. I would argue, however, that it has less to offer methodologically; it does not provide an explicit toolbox for researching the ways in which individuals experience power or the ways the latter manifests itself in health beliefs, practices, and decision-making processes. For this I turn to anthropological theories of the body.

Anthropological Theories of the Body and Human Reproduction

Anthropological studies that problematize biologically reductionist views of the human body in health act as theoretical tools that encourage researchers to see power dynamics as they manifest themselves in the bodies and lives of individuals. I take the work of Scheper-Hughes and Lock (1987) as a useful starting point (while these scholars also identify as critical medical anthropologists, their work, I believe, expands upon the core tenets of CMA in way that lends itself to designing research methodologies that remain sensitive to power dynamics). In their 1987 article, "The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology," they describe three different ways to approach the body.

First, they describe the body as an individual "body-self," that possesses its

own unique lived experience. This approach rejects the Cartesian mind-body dualism that traditionally categorizes Western biomedicine and is wary of any logics that operate as dichotomies (nature/culture, self/society, etc.) for their tendency to oversimplify human experience. Instead, it opts to create a language with which to approach lived-experiences of health and illness in a more holistic way.

The second way in which Scheper-Hughes and Lock approach the body is as a social body, “a natural symbol with which to think about nature, society, and culture” (1987:7). They give as examples anthropological accounts of different societies in which the health of the society, the natural world within which humans live, and the health of an individual are seen as inextricably linked. The Qollahuaya of Brazil, for instance, see the health of the mountains as inextricably linked to their individual well-being and, as a result, give offerings to the mountain when people fall ill (1987:8). Scheper-Hughes and Lock contrast this body-as-mountain symbolism with the body-as-machine metaphor that thrives throughout much of the industrialized world.

The third body, the body politic, is the body regulated, placed under surveillance, and controlled. This approach draws heavily from the work of French theorist Michel Foucault, whose work deals extensively with tracing systems of power (1977). In his analysis of how disciplinary systems evolved into our current hierarchical systems, Foucault argues that bodily discipline functions via what he calls power/knowledge. Rather than acting directly on the bodies of individuals, as with public corporeal punishments, this type of power/knowledge affects people indirectly

through population control and surveillance through societal norms and the institutions through which they flow. With its focus on tracing power through multiple levels of analysis, CMA draws heavily upon this approach.

I utilize this “three bodies” approach by eliciting personal birth narratives, then analyzing them through multiple levels of analysis (namely, the personal, social, and political). Using personal narratives to examine theories of health is a practice that Arthur Kleinman, a medical anthropologist, pioneered through developing the idea of an “illness narrative” (1989). By eliciting an individual's story of what it means to be ill, it becomes possible to better understand what he calls “explanatory models” of illness. In other words, by listening to the ways people talk about their well-being, we learn how they make sense of sickness and health on their own terms. The same principles Kleinman uses to analyze the experience of illness can be transferred to an understanding of birth narratives, though birth, especially in this research population, is not perceived as an illness. When a woman narrates her birth experience, she is giving voice to her embodied experience of birth—one that exists simultaneously both within the physical body and in her relationship to the wider social and political forces that shape birthing norms and options in her world.

Together these three approaches to the body provide a useful framework for analyzing the choices women make surrounding their pregnancies. These ideas are intermittently found, elaborated upon, and used to make sense of women's experiences in a number of anthropological works on human reproduction. Particularly relevant to

this study are Jordan's comparative study of birthing systems and her call for mutual accommodation between different models of care (1978); Davis-Floyd's study of the symbolism inherent in mainstream American obstetric practices (1993); Martin's analysis of women's bodily experiences alongside a textual deconstruction of scientific and obstetric texts (1987); and, finally, Rapp's comprehensive, woman-centered approach to amniocentesis in the United States (2001). Not only do these works provide important examples of the holistic analyses of women's health as it is simultaneously lived, socially constructed, and politically implicated, they also enhance Critical Medical Anthropology's focus on systems of power by providing theoretically rich, and detailed examples of the ways inequalities manifest themselves in women's experiences of reproductive health.

Feminist Bioethics

Feminist bioethicists have traditionally worked on addressing moral issues surrounding women's health, although their approaches are not limited to the study of women. Feminist bioethicists adopt a stance that is explicitly concerned with creating a more socially just system of health (Nelson 2000). In doing this, its reasoning and methodology depart from traditional bioethical theory in several important ways. First, rather than starting from a position that privileges universal moral claims, it grounds ethical considerations in specific contexts. Second, it recognizes that a given context is always linked to wider systems of power and oppression. Finally, these approaches view individuals as relational beings rather than autonomous decision-

makers (Donchin 2009, Ellis 2003, Nelson 2000).

Collectively, these facets of feminist bioethics make it extremely well-suited to complement both CMA and the “three bodies” approach described by Scheper-Hughes and Lock (1987). For example, Ellis (2003) problematizes the notion of informed consent by examining the ways in which Foucault's notion of power relationships influence one's identity, as well as the ways that individuals make decisions regarding their health. Combining this analysis with the normative nature of feminist ethics, she concludes that informed consent in health care must focus not on the individual as an autonomous decision-maker, but rather on the decisions themselves—decisions that are situated in relationships that inevitably involve power.

Nelson (2000:505) suggests using narrative as a means to achieve such a contextualized view of ethical decision-making, one that describes morality as:

a continuous interpersonal task of becoming and remaining mutually intelligible. It is expressive of who we are and hope to be; it is collaborative in that it posits, not a solitary judge, but a community of inquirers who need to construct ways of living well together. And it is feminist because it offers a means of resisting powerful ideologies, whether these be of gender, medicine, ethnicity, or all three at once.

This suggestion creates a space for anthropological insights and methodologies. It also can function as an invitation to expand Kleinman's illness narratives (1989) to explain not only the experience of illness, but also the moral dilemmas that can arise in a medical setting.

Combining Theoretical Perspectives

In this chapter, I have argued that CMA, anthropological theories of embodiment, and feminist bioethics combine to provide a set of analytical tools to holistically interpret how women decide to give birth at home in political and social climates that often do not see this option as a safe or reasonable choice. In the next chapter, I discuss how these theoretical insights inform the specific methodology of this study.

Chapter Four: Research Methods

In this study, I combine a demographic recruitment survey (Phase I) with in-depth, semi-structured interviews (Phase II) and focus group data (Phase III) in order to better understand and represent how women decide to give birth at home in downstate Illinois. The study sample consists of twenty-one (n=21) women who have given birth at home in the last three years in this region of the state. In addition to formal surveys, interviews, and focus groups, I also engaged in participant-observation at childbirth education classes, breastfeeding support groups, natural parenting groups, in on-line homebirth message boards, and at legislative events including time spent at the state capitol on a day when the Homebirth Safety Act (SB3712) was expected to be called for a vote. Through an internship with the Coalition for Illinois Midwifery (CFIM), a consumer advocacy organization working toward legal recognition of the Certified Professional Midwife (CPM) credential, I gained additional insight into the legislative process, the history of political advocacy efforts in the state, and the politics of birth in Illinois.

I analyze all data was using a modified grounded theory approach (Charmaz 2006); an approach that allowed themes to emerge organically from the words and experiences of participants. I attempted to interpret these themes in a way that remained true to the collective logic of the study sample.

Site Selection

My project was based out of two sites in the downstate area—one site in a

more central region of the state and one site in a more southern region. By focusing on the experiences of women living in two distinct regions of Illinois, I was able to see how the effects of a state law manifest regionally, as well as within the stories of individual women. Because homebirth is such a highly politicized topic in Illinois, individuals on both sides of the debate tend to be passionate advocates for their point of view. However, because, it is ultimately the mothers who choose homebirth and it is they and their babies who live the effects of our health policies, it is essential to gain a better understanding of why and how they make decisions regarding place of birth. This is an important first step if we are to be able to create a system of maternal and infant health that addresses the real needs and desires of the mothers and babies whose health is ultimately at stake.

Phase I: Demographic Recruitment Survey

After receiving approval from the Institutional Review Board (IRB) of Oregon State University, I distributed recruitment surveys to potential participants. The Coalition for Illinois Midwifery supported the recruitment process by distributing an electronic version of a survey through a select number of independently employed childbirth educators. The survey included a brief introduction to the study, its purpose, confidentiality information for participants and their providers, and a description of what participation would entail.

Interested individuals returned the survey with contact information. This survey also included a place for participants to provide basic demographic information

about themselves including age, number of children, number of children born at home in Illinois, estimated annual household income, and highest level of education achieved. Finally, the survey provided an open space for participants to answer the question, “How would you describe your experience seeking a homebirth in downstate Illinois?”

I received responses from twenty-four participants who were interested in being contacted for an interview. Of those, I only interviewed twenty-one women due to time constraints and the fact that I reached concept saturation (Charmaz 2006) at this point. Concept saturation refers to a point at which no new themes emerge from interviews; this point acts as a signal to move into a phase of research that is focused on data analysis.

Phase II: In-depth, Semi-Structured Interviews

Once a woman indicated her willingness to be interviewed, I contacted her either via phone or email. Together we set a time and place to meet for the interview. I left the place of interview open to study participants, most of who opted to meet at their homes. Many of the women I interviewed stayed at home during the day with their small children, and approximately half of them were homeschooling. Thus, meeting at their homes often proved the most convenient option for study participants. Other places women chose to meet included a classroom studio space provided to me by a local childbirth educator and in area coffee shops or restaurants.

Interviews last between forty-five minutes and two hours, with an average

length of an hour and fifteen minutes. In most interviews, mothers and some or all of their children were present. In four interviews, women and their partners both participated. Interviews were open-ended and semi-structured, meaning that I started interviews by asking women to describe their birth and pregnancy experiences and then added additional questions as needed for clarification or elaboration. I also asked women whether, and if so, how they believed state laws or hospital protocols had affected their experiences of seeking care.

After the first few interviews, I realized what profound impacts previous pregnancies had on women's decision-making with subsequent children. In keeping with the tenets of grounded theory (Charmaz 2006), I then began asking women to describe their birth experiences starting with their first child, regardless of where that birth occurred, encouraging them to link their initial experiences with the ways in which they made decisions with later children. I realized after initial interviews that the themes of social support and combining models of care were repeatedly present. In later interviews, I made a point to ask explicitly about these themes if women did not independently touch upon them in their stories. At the end of each interview, I asked women if they had any additional information they wanted to share about their births in general or about homebirth in the area. If such topics were not initially explored in those first few interviews, I contacted participants with additional questions.

With the informed consent of all participants, I recorded all interviews and

transcribed them verbatim into OpenOffice 3.1.1 text documents. I also took notes throughout the interviews themselves, a process which helped me to formulate clarifying questions as they arose and to remember them at appropriate points in the interview. Taking notes during interviews also allowed me a means to record any nonverbal communication that arose. After transcribing each interview, I gave all participants the option of receiving a written copy of the transcription and the opportunity to contact me with any corrections and additional information that they saw as relevant. Three women accepted this offer; they wrote to or called me with comments.

Phase III: Focus Group Discussions

After all interviews were recorded, transcribed, and coded, I held two focus group discussions—one in the Southern region and one in the Central region. While I tried to hold these groups at times and places that would be convenient for all participants, it quickly became apparent that such a task, though well-intentioned, would prove impossible given the busy schedules, childcare needs, and disparate geographic locations of the participants invited. Families and children were welcome to attend, and there were light refreshments available to all attendees. In total, ten adult participants (n=10) attended these groups, each of which lasted approximately two hours each.

Focus group discussions provided a forum for participants to hear initial research findings and analyses, as well as to comment on them. It also provided a way

for me, as the researcher, to ask additional questions designed to help clarify and contextualize themes. Because of the reciprocal nature of these focus groups, they acted as a means by which to strengthen the validity of the study's findings. As Bernard (2006) explains in his landmark guide to research methodologies for anthropologists, focus groups, when used in conjunction with other methods (such as individual interviews and survey data, in the case of this study) are a way to show that the same findings can arise using multiple research tactics. He also points out that they are especially apt for collecting data on processes and content (2006:236), making them especially relevant for this study on women's decision-making processes when seeking homebirth care.

In practice, the focus group discussions helped to reduce the inherent power-imbalance between the researcher, who ultimately has the power to represent the words of participants, and a study's subjects, who's voices might otherwise be absent from the analytical phase of a project. Participants who attended a focus group had the opportunity to correct or comment on my initial findings and themes before I had written up my research. Taking their comments to heart, I feel these groups helped to improve the validity of my research.

Data Analysis

I analyzed all data using modified grounded theory (Charmaz 2006). I use field notes gathered from participant observation, as well as transcriptions as the textual basis for this analysis. All material was first hand-coded using grounded

theory principles.

Grounded theory emerged in the 1960s through the work of sociologists Glaser and Strauss. They saw it as a method that would allow researchers to develop research questions and theories grounded in empirical data, rather than using deductive reasoning to base research agendas wholly on preexisting theories. Charmaz (2006) along with other social scientists (see also Clarke 2003) have refined Glaser and Strauss' original method, bringing it into closer alignment with the postmodern call for researchers to be more sensitive to their own positionality.

Modified grounded theory (Charmaz 2006) as a method of data analysis begins by gathering rich ethnographic data. This data comes from listening to and respecting study participants, while making an effort to understand their experiences from their own perspectives. As researchers collect data, they concurrently begin data analysis through coding. Coding occurs in two phases. First, in initial coding, the researcher creates short, active codes that stay close to the data. Codes serve as ways of describing an interview, field notes, or other textual reference—an effort to spark a sort of analytic imagination and force the researcher to see his or her data in new and unfamiliar ways. After completing the process of initial coding, the researcher makes a conscious choice of how to sort through and selectively combine the most important codes. These decisions propel the researcher into a process of more focused coding. After coding data, Charmaz (2006) suggests memo-writing as a way of delving more deeply into the data before actually writing a draft of the results. Generally speaking,

memo-writing consists of writing exercises designed both to think more critically about the subject matter and to hone authors' confidence in their own voices and the ideas those voices are struggling to express. Memo-writing leads to the final stage of grounded theory research in the sense that it helps to form the categories used in final analyses.

Study Limitations

The major limitation to this study was the sensitive nature of the topic at hand. Homebirth is a highly marginalized practice in the state of Illinois, as illustrated not only by the legal standing of DEMs, but also by the responses that homebirth mothers received when they told friends and family about their birthing choices. Because birth is a highly medicalized event for the majority of women in their communities, those who chose to birth at home were often accused by friends, family, and those working within medical institutions of acting irresponsibly. Sometimes couples told no one of their plans until after the birth. While I was in the field, a family who had transferred care to a hospital after a homebirth had their newborn taken from their custody as a result of their choice of birthplace. I also heard stories of the Department of Child and Family Services being called to investigate women who gave birth at home and women who gave birth in the hospital and opted out of routine newborn procedures. I also learned through interviews about midwives who had either stopped practice or left the state due to legal pressure. As I became increasingly aware of the extent to which homebirth is marginalized in this part of the world, my commitment to

maintaining the confidentiality of all participants and their providers was reaffirmed.

Confidentiality was one factor in my decision to limit this study to the experiences of mothers only. However, by limiting my analysis to the decision-making processes of mothers, many other perspectives on homebirth simply do not appear. The perspectives of the midwives themselves remain absent from my analysis, though I drew from the work of Cheyney (2010) for insight into this area. Also absent is the perspective of doctors, nurses, and other medical workers with whom women may seek to combine care along with those of senators and legislators who are, at the time of this writing, considering a bill that would recognize the CPM credential.

I was not able to gain access into the Amish communities living in the area, a group that primarily opts to deliver its children at home. This is reflective, primarily of time constraints. I also did not interview women who wanted a homebirth and were not able to find a provider. Through casual conversations while living in the field and attending local parenting groups, I realized that there is a significant group of women in the Southern Region of the state that simply cannot find a homebirth provider and so they are forced to choose a hospital delivery. At one meeting, I talked with a woman who was considering not having any more children simply because she could not find a homebirth provider in the area whom she trusted. Casual conversations also revealed that significant changes in the atmosphere for homebirth had occurred in the past generation. A historical analysis of changing attitudes toward different birthing options in the downstate area and their effects on the availability of providers would

be a fruitful avenue for future research.

Study Population

Basic Demographic Data Regarding Study Sample

	Average Age of Mother	Annual Household Income	Highest Level of Education of Mother	Average Number of Children/ Average Number of Children Born in the Hospital	Number of Women Who Birthed at Least One Child in the Hospital (%)
Southern Region (n=10)	32	\$45,800	HS=10.0% BA/BS=50% MA/MS=40%	3(1)	6 (60%)
Central Region (n=11)	32	\$58,545	HS=9.0% AA=18.0% BA/BS=64.0% MA/MS=9.0%	3(2)	8 (72.7%)
Total Sample	32	\$52,127	HS=10.0% AA=10.0% BA/BS=57.0% MA/MS=24.0 %	3(1.5)	14 (66.7%)

All study participants were women who had given birth at home in downstate Illinois within the last three years. Of the total study sample (n=21), ten women (n=10) were from the Southern region and eleven were from the Central region (n=11). In the Southern region, the average age of participants was 32 and the average annual household income was \$45,800. In this subset, the highest level of education varied; one woman had a high school education, five women had bachelor's degrees and four had master's degrees. The average number of children was three, while the average number of children born at home to a participant was two.

In the Central region, the average age of participants was 32 and the annual

household income was \$58,545. In this subset, the highest level of education varied; one woman had a high school education, two women had associate's degrees, seven women had bachelor's degrees and one had a master's degree. The average number of children was three, while the average number of children born at home was one.

Of the total sample (n=21), 15 women (71.4%) had hospital births for one or more children before choosing to birth at home for subsequent children. Six women had at least one cesarean section in the hospital before choosing to birth at home for subsequent children (28.6%). In terms of race/ethnic identity, it is important to acknowledge that approximately $\frac{3}{4}$ of this study sample is white. The other 25% is comprised of Latina, South Asian and African American participants. Other anthropologists studying homebirth have analyzed the relationship between ethnicity and birth choice in the United States (Craven 2007, Fraser 1998), locating women's choices, as well as the options available to them at the intersection of race, gender, and class-based systems of oppression. While class, ethnicity and birth choice were not the explicit focus of my study, I recognize in compiling demographic statistics on participants that not all women were white, upper-middle class women. I also recognize that ethnicity and socioeconomic class can play a significant role in a woman's decision to birth at home. While not exhaustive, the demographic statistic compiled through the recruitment survey help to contextualize the results of the study, to which I now turn.

Chapter Five: Results

Grounded theory analysis of women's birth narratives allowed me to identify three key themes, and associated subthemes that help to explain how women think about and create meaning around their decisions to give birth at home in an illegal state: 1) reflecting on past birth experiences, 2) seeking care, and 3) advocating for change. These three themes emerge in women's stories starting when mothers begin to consider homebirth as an option; they continue throughout the process of seeking care and into the postpartum period.

Although all study participants gave birth in the same state, regional differences in the availability of care strongly affected women's decision-making experiences. In areas where there were no legal homebirth providers, women tended to look longer and struggle more to locate appropriate care than did their counterparts in areas where midwives practiced legally and openly.

Despite regional variation in women's experiences, study participants from both regions considered other women's birth stories to be crucial as they made the initial decision to stay at home. In addition, women throughout the study sites considered others' ignorance about normal birth and the variety of options available to birthing women to be the most salient barriers to integrating homebirth into the maternity care system in the state. This strongly affected the strategies women used to try to change the status quo of birthing culture in their communities.

Reflecting on Past Birth Experiences

When participants found out that they were pregnant, they reflected on past

birth experiences as a way to start thinking about the type of care they wanted for their current pregnancies. Women who already had children thought about their own personal childbearing experiences. They also, along with first time mothers in the sample, reflected on the birth stories of friends and family members. In addition, participants reflected upon other, less direct ways of knowing about birth that had made a lasting impact on them—safety studies, books, movies, television, etc. Three subthemes associated with the larger theme of reflecting on past birth experiences are: 1) learning from embodied experience, 2) critiquing the technocratic model of birth, and 3) valuing autonomous decision-making. Together these subthemes reveal the ways women critically reflect on what they know about birth in order to critique the dominant paradigm of hospital birth and to articulate the factors that are important to them as they consider alternative maternity care options.

Learning from Embodied Experiences

By talking with other mothers and thinking back on their own birth experiences, all women in this sample came to a point where they decided that they wanted to have a homebirth. While each individual's particular reasons for making this decision varied, all wanted to be able to make decisions for themselves and their babies and to feel respected in the choices that they made. For example, Tami said:

I think, as a woman it's so important to not have other people making decisions about your body, baby, and care. It was a really big deal for me to be able to make those decisions for myself.

Autonomy and respect are major factors in women's decision-making. Women talked

about how important it was for them to find a care-provider that practiced using a model of shared decision-making in order to create a space for women's voices during pregnancy and labor.

Because the vast majority of women in the state of Illinois deliver their babies in a hospital setting, study participants were all well aware that in choosing to birth at home, they were acting outside of the norm. Nonetheless, women talked about homebirth in relation to stories and personal experiences of labor in the hospital. Stories of hospital birth became a salient factor in women's decisions to stay home. As Nina described it:

I was seeing an OB and then I started becoming more and more involved with the mothering group in town. I was talking to other people who had homebirths and there was a difference between their stories and some moms who had a hospital birth and they decided they wanted to have a homebirth afterwards because the experience was so traumatic. So I figure, if I have the chance to have a homebirth with my first, then why not do that? Why go through with a traumatic experience first before I decide? Why not learn from myself? I can learn from others and use their mistakes to make sure I don't make the same.

Another mother said:

My older sister had her first two children in a hospital. It was one of those things where she could hardly talk about it. And she would say things like, "I can't even describe it. I felt ~~so~~ vulnerable and ~~so~~ mistreated at my most vulnerable time in my whole life." (Sonia)

Such stories became especially powerful as women began to independently research the safety of homebirth in books and online.

Critiquing the Technocratic Model of Birth

When women reflected on their own past hospital births, they remembered how difficult it was to “stick up” for themselves in the hospital during labor. Patient autonomy and respect are not necessarily values that mirror the technocratic model (Cheyney 2010; Davis-Floyd 1993, 2001) of birth in a hospital setting. Women in this study describe the birthing model found in the hospital in ways that are strikingly similar to those documented by anthropologists Emily Martin (1987) and Robbie Davis-Floyd (1993) over fifteen years ago.

In *Woman in the Body: A Cultural Analysis of Reproduction* (1987), Martin interviewed women from a variety of ethnic and class backgrounds about their experiences of health, especially as it related to reproduction (menstruation, childbirth, menopause, etc.). Alongside the insight from these interviews, she critically read textbooks focused on human reproduction, finding in them powerful metaphors of the female body as a faulty machine. Martin shows that when women go to the hospital to give birth, they are subject to the same types of logic that guide production in a factory. She explains that hospital personnel treat women’s bodies as baby-producing machines in the hospital. In this situation, women begin to feel that control over the birth lies in the hands of the obstetricians. Women in this study used factory metaphors similar to those described by Martin:

It was so striking to me how *different* it was [being at home] from being in the hospital where it was very much like they just push you through on this conveyor belt and you have to do things a certain way. (Amy)

Another participant described a similar production metaphor:

You're treated like you're on an assembly line. It's not really your body. It's this little thing that's holding a person inside, or a thing inside. It's *inside*, let's go get it!
(Karen)

This same participant also commented on the sense of ownership and control over birth she experienced in the hospital:

It is definitely very much, it's like you're not a person. You belong to the hospital at that point. Your baby is not your baby; the baby belongs to the hospital. (Karen)

While Martin's analysis focuses primarily on the ways women's experience of hospital birth relate to powerful production metaphors surrounding the female body, Davis-Floyd (1992) focuses on hospital birth as it reflects and reproduces our society's key values, in particular, our faith in technology and hierarchical control. The latter argues that what have come to be seen as standard obstetric practices and protocols are actually our culture's way of sending powerful messages to birthing women and their families about who is in control (the obstetrician) and what is important (to trust in the power of technology). Davis-Floyd finds that whether a woman describes the experience of technocratic birth to be empowering or disappointing hinges on the beliefs that any given woman carries with her to the delivery room.

Valuing Autonomous Decision-making

In this study, when what birthing women expected and wanted did not match up with the routines and practices they encountered in hospitals, they spoke of being “ready to fight” to have their needs listened to and respected. As Amber described:

In a hospital, I would have to be advocating for our position. I'd have to be kind of safeguarding our wishes in a way that I didn't have to do at home. In the hospital you go in with a birth plan and then often, from what I hear, the birth plan is thrown out, especially if things deviate at all from what's expected. And then you have to fight for these things.

Another participant, Tami, stressed that advocating for options outside of hospital routines is a process of “going against the grain.”

The routine at the hospital is a routine and anything that you want to do differently is going against the grain. It's a constant fight in the hospital to get what you want. I mean just something as simple as not wanting the cord clamped for five minutes after the baby is born is something that they don't do routinely. So you're going to have to be on constant alert after your baby is born.

When women's needs and expectations of birth did not match up with their experiences in the hospital, they struggled to voice their needs from a position of vulnerability.

As women progressed further into labor, they found it increasingly difficult to advocate for themselves and described feeling increasingly vulnerable; at a certain point in labor, they were so focused on the birth itself that it became difficult to verbally communicate with others. Issues of control and autonomy became crucial as women narrated their experiences trying to manage both their labor and the responsibility of sticking up for themselves in the hospital. The hospital was described as a place where doctors, not women had control. Eve said:

It's just like, you go and you get strapped down and you get stuck and then you have to get naked. Who wants to give birth that way? And then you give into the

interventions and the process of, “Okay I’ll just let you take care of it because this is *your* place, I don’t control this.”

The idea of the hospital as a place where one has little control recurred as women talked about the many instances during labor where they were cognizant of “wanting something different” for themselves. Elise said:

More and more I began to realize how intervention-focused they were and what little say I really had. Like even from whether or not I walked to the unit or rode in a wheelchair, whether I had an IV-port ready. And we were signing lots and lots of forms with every birth saying, “We’re refusing this, we’re refusing this, we’re refusing this.”

Many women who had previously given birth in a hospital setting, especially those who had what they considered unnecessary cesareans, expressed feelings of victimization if they did not feel that their providers in past labors had listened to them.

As they reflected on others’ stories and/or personal experiences in a hospital setting, participants chose to birth at home because they saw it as a setting where they would be able make their own decisions with a provider who they could trust to respect their autonomy during labor. Because homebirth midwives tend to value shared models of decision-making (Cheyney 2008; Davis-Floyd 1993), women—regardless of previous birth experiences—generally felt that they could trust their providers to be supportive of them throughout pregnancy and birth. Women who birth at home in an illegal state reflect on past birth experiences as they make the initial

decision to stay home. This involves learning from embodied experiences of birth, critiquing the technocratic model of birth, and voicing the desire to make decisions for oneself during throughout childbearing. Women reaffirm this initial decision as they go through the process of seeking care.

Seeking Care

Once a woman decided to have a homebirth, she went through a process of laying out all her options before seeking care. This theme has three associated subthemes: 1) encountering barriers to seeking home-based midwifery care, 2) creatively combining care, and 3) moving toward mutual accommodation. In the areas where I conducted this study, women's options were extremely limited. As I described in the methodology chapter, I had two primary research sites. In the Central Site (A), there were two Certified Nurse Midwives (CNMs) who were legally able to provide homebirth care. In the Southern Site (B), there were no local homebirth providers at all, and women struggled much more in their search for care.

Encountering Barriers to Home-Based Midwifery Care

Because in Site B there were no legal midwives practicing in the area, women described an arduous process of looking for a midwife. It was not uncommon for women to search into the second, or even third trimester of their pregnancies for a care provider, becoming increasingly anxious as time passed. Louise described her experience this way:

Trying to find a midwife who we felt would give us a safe birth was very, very stressful, especially as I moved

further along in my pregnancy.... I was frustrated and nervous that I was moving along in the pregnancy and it was still up in the air what we were going to do. It seemed like we were going to have a hospital birth. I'm *already* wondering what we will next time, in case the midwife I used is no longer doing births in Illinois.

When women finally found a provider, they often spoke of how thankful they were that they felt like the midwife was both professionally competent and a “good fit” in terms of personality. In order to assess a midwife's competency, women relied on word-of-mouth recommendations, as well as on interviews where women were able to ask the midwife questions about her training, professional experience, safety record, and practice protocols.

Because there are so few midwives practicing in Illinois, women sometimes had to convince a midwife to take them on as a client—especially if the midwife had to travel into Illinois from another state. In these cases, women would often travel to the midwife for the majority of her prenatal care. Alma said:

I had to go to the midwife's house for prenatal appointments, which was an hour and a half drive. We had meetings once a month; other moms were there with their husbands and kids.

Women in this study were willing to travel up to twelve hours to seek midwifery care, and the average distance between a woman and her midwife was two hours. When women could find no suitable provider living in or willing to come to their area, they would leave the state themselves, go to the hospital or have an unassisted birth.

In site A, where there were two CNMs who were legally able to provide

homebirth care, women's stories of finding a midwife were starkly different. Here there was a closely-knit community of parents who were able to use one another as resources for midwife referrals. Because their midwives did not face any legal threat for practicing, women were able to talk more openly about homebirth without fearing for the safety of their providers. Eight women in my total sample delivered their babies at home with CNMs, representing 73% of women in site A (n=11) and 38% of the total sample (n=21). With the exception of one woman, who had recently moved to the area, none of these women had any difficulty finding a midwife. Among this group, stories of finding a midwife looked something like this:

Because my cousin had a homebirth and I know the parenting group in town, I knew who to call around here when you're going to plan a homebirth. As soon as you pee on a stick you pretty much have to call because there are only two midwives and they can only handle so many births a month and they fill up. They can't take too many. So as soon as I found out I was pregnant, I thought, "Okay, well I'd better call her." (Karen)

Demand for midwives' services overwhelmed the few providers in the area. The other two barriers women encountered were related to their risk-status and to the cost of care.

Women with legally practicing midwives often paid all or most of the cost of their care out-of-pocket, and all women using Direct-Entry Midwives paid their providers out-of-pocket. The cost of midwifery care ranged from \$700-\$2500. Despite the fact that this is much less than the average hospital birth, cost can still pose a formidable barrier for women. As Liz described:

This time, money-wise, we just could not afford to have the midwife that I had spoken to.... I'm still hoping it works out so I can have a homebirth. I think it probably will, even if we have to do it ourselves.... I don't know how it's going to end up. I can't see the future but I really don't want to be in the hospital. I mean I'd like money to just float down from heaven (laughs). Sure, that'd be nice, "Pass me a check!" I don't really expect that, but we'll see. I don't know. That's definitely not the kind of thing you just go and tell people. Because people are shocked enough if you say you want to have a homebirth with a midwife. But if you say you want to have a homebirth and you're not even going to have anyone there with you other than a friend and your husband...I don't really want to, but what's my other option? My other option is something I want even less.

Because study participants almost always had to pay out-of-pocket for homebirth midwifery services, the ease with which women could financially access care depended entirely on her family's socio-economic status. The cost of a homebirth was an enormous financial strain for some families, especially those with lower incomes.

Another type of barrier women in both sites encountered as they sought homebirth midwifery care relates to their risk status as a patient. Depending on the type of license a midwife practices under, there are certain risk factors that make some women ineligible for care because they are considered too "high risk." Because midwives specialize in low-risk deliveries, issues of who gets to define risk, how it is defined, and the effects of "risk" on a woman's decisions became important factors in some women's homebirth experiences (Cheyney 2010), starting with the process of seeking care. The one risk factor that most significantly affected a woman's ability to

seek care in this sample was whether she had had a cesarean section in a previous birth.

The homebirth CNMs practicing in the study area were not able to attend any woman who had had a cesarean section for the birth that immediately preceded the current pregnancy, nor could they attend any deliveries for breech babies. Both of these prohibitions are the result of insurance restrictions. Many women wanted to have a Vaginal Birth after Cesarean (VBAC) at home simply because they did not think that they would be able to have a vaginal birth in the hospital. Women from site A who wanted a VBAC homebirth and were risked out of a CNM-attended birth had stories of seeking care that resembled those of women living in areas with no locally available care providers.

Creatively Combining Care

Women who had a homebirth with a CNM moved easily between homebirth midwifery and traditional obstetric care and biomedical testing. Because their providers were practicing legally and had established relationships with back-up obstetricians, these women were able to easily coordinate and transfer care with physicians and hospitals should the need arise. Women having homebirths with DEMs and those having unassisted homebirths differed widely in how easy it was for them to combine homebirth care with other forms of care, depending on the individual providers whose services they sought. Women who had negative stories of going to the hospital because they needed biomedical assistance talked about their experiences

in terms of further solidifying the image of the hospital as “a place where you won't be listened to.”

Although all women in this study wanted a minimal amount of medical intervention in labor, participants varied in the types of prenatal tests and newborn procedures they sought. As other researchers have noted (Cheyney 2010, MacDonald 2006), women create different ideas of what having a “natural birth” entails. I found that most women planning a homebirth desired or relied on medical expertise at some point. Many participants, especially first-time mothers talked at length about how their midwives were open to answering questions, talking through women's concerns, and helping them decide what types of procedures they might want to coordinate with other providers. Ultimately, women felt a sense of ownership over these decisions.

Tami explained it this way:

I got used to the idea by the end of my pregnancy that she [the midwife] wasn't going to tell me what I needed to do, that I was going to have to do the research by myself. And I liked that a lot. At first it kind of scared me that I had that power to choose those things, but now I realize that I'm glad that she left all that up to me and didn't try to sway me one way or the other. She just gave me the information and I was able to make my own choice.

Women who had a CNM-attended homebirth talked about how their midwives were able to work with them to coordinate tests and procedures with appropriate care providers quite easily. The success with which all other women in the sample combined care was based entirely on luck. If a woman found a sympathetic physician or nurse, she was in luck. If not, women struggled to find appropriate treatment and at

times were refused care by the medical establishment.

One common strategy women used to improve their chances at selectively combining biomedical and midwifery care, as well as preparing for the possibility that they might at some point need to transport to a hospital during or after labor, was to engage in a practice they called, “shadow care.” Shadow care involves simultaneously seeking care from multiple sources, most commonly, from a homebirth midwife and an obstetrician.

The most common barrier to successfully seeking care from multiple providers was disapproving attitudes from medical personnel. As Olivia explained:

There was no question that homebirth would be the option. I still went ahead and made my appointments with Amanda [a hospital-based CNM], because she's one of the best midwives in the area and I didn't know how things would play out... I called billing to ask how much prenatal appointments would cost without a birth. That red-flagged me right away. I shouldn't have said that. Then Amanda said to me at one of our first appointments, “If you are going to have a homebirth, do not tell me.”

When women ~~were~~ able to successfully coordinate shadow care, it gave them a feeling of relief because they were able to easily and selectively access ultrasounds, and other forms of prenatal testing.

When women did not have a shadow-care provider or a legally recognized homebirth CNM, they often struggled to combine different models of care. If a woman needed to transfer care (which in this sample only occurred during or after the third stage; in all cases, the infant had already been born) she was entirely at the whim

of the individual providers whose care she happened to transfer into. In some cases, everything went smoothly. For example, when Amy and her husband went with their newborn hours after his birth to a hospital to have a perineal tear sutured, they described their experience this way:

The nurse and physician that sutured me were actually very, very gentle and kind. I was worried about the possibility that someone would say, “Well you're crazy and what are you doing here?” But nothing was ever said—we talked about our kids, we talked about his job. They were just very cordial and kind and I was very pleased overall with the experience because ultimately I was coming in for a service and they provided it.

However, this type of experience was the exception rather than the norm. In most cases, women were treated as selfish and irresponsible if they contemplated or completed a home delivery. The same metaphors women used to describe labor in the hospital, such as, “being alert” or “ready to fight,” re-emerged as women described how protective they felt in situations when they were not sure whether their decision to birth at home would be treated as evidence that they were irresponsible.

Moving Toward Mutual Accommodation

In choosing a homebirth women are not wholeheartedly rejecting the tools and treatments of biomedicine. Rather, they selectively adopt the procedures that they deem necessary in a very pragmatic way, according to their individual needs and concerns. This is much easier for women whose midwives practice legally because they have established professional relationships with back-up obstetricians should a transfer of care become necessary for any reason. On the other hand, women who

have homebirths without a legally recognized provider struggle more to combine care with medical providers. If they require hospital-based care at any point, the type of treatment they receive varies depending on the individual providers they encounter. The major complaint of women seeking to combine hospital-based care with midwifery care hinged upon feeling judged as irresponsible by hospital staff and not treated with respect.

These types of judgments stem from ideologically charged, authoritative views of birth (Jordan 1997). By judging others' decisions surrounding birth rather than seeking to understand why some women make decisions that fall outside of the obstetric norm, an atmosphere arises where women do not feel safe and supported in their birth choices. This atmosphere is present not only in interpersonal interactions with friends, family, and care providers, but also in the legal regulations and safety debates that define birthing choice discourses in Illinois. This atmosphere severely limits out-of-hospital birthing options for women in downstate Illinois. Judgment also carries with it a subtext of irresponsibility, which often leaves mother feeling as though their wishes are being cast as somehow contrary to their infants' well being.

The authoritative nature of understanding birth in the context of downstate Illinois leads to the unintentional effect of silencing women, especially when they voice a desire for care that falls outside of the norm. In the United States, birth is a highly medicalized event that is widely considered to require the expertise of an obstetrician in a hospital setting. As Jordan (1978, 1997) reminds us, one of the key

facets of authoritative knowledge is that it renders other ways of knowing illegitimate and irresponsible. She sees the authoritative nature of a given culture's birthing system as an obstacle to creating “mutual accommodation,” or, in other words, models of maternity care that support multiple ways of caring for mothers and their babies.

In this vein, women seeking alternative forms of maternity care in an illegal state are often not taken seriously by medical practitioners, legislators, insurance companies, or, at times, by friends and family. Recognizing power dynamics inherent to homebirth mothers' interactions with others can serve as an important way of tracing authoritative knowledge as it moves through society.

Examining how homebirth mothers in downstate Illinois choose to stay home reveals the active role that mothers play in creating systems of health for themselves, even when options are extremely limited. Women created mutual accommodation between homebirth care and biomedicine, even though they often struggled with judgment from medical providers in their quest to selectively combine care.

Advocating for Change

After having a homebirth, study participants were committed to changing the status quo of birth in this context. Subthemes associated with this key theme include: 1) educating others by speaking from embodied experience and 2) committing oneself to changing state laws. The ways women advocated for change depended in part on whether a midwife had legally attended a woman's labor. Women who had legally practicing homebirth midwives were much more open in talking about their birthing choices. Homebirth mothers who were not attended by a legally practicing provider

were much more selective in talking about their choices, mostly out of concern for the safety of their midwives.

Educating Other by Speaking from Embodied Experience

In areas where there are not strong networks of other homebirth mothers, some participants found the internet to be a place where they could find communities of like-minded people to communicate with as they planned their birth. Amy said:

When I was planning for my first homebirth it [finding online support] was *instrumental*. Not only was it just wanting to hear other stories to hear about other people's success so that you could get confident in having your own success, it was also just that camaraderie of, "Yeah! You can do this! Your body is made to do this and you're not going to die if you have a homebirth."

When women expressed themselves online, they were able to do so somewhat anonymously, thus freeing themselves from concerns of confidentiality and social disapproval. As Eve explained:

From the online community I found a lot more support. Because there *are* a lot of people doing it, it's just that it's not talked about so much because people, you know, think you are insane.

Furthermore, because online communities are self-selecting, women could find pockets of women in similar situations to learn from and share stories with.

After women gave birth at home, they were excited to talk to other women; not only about their own personal experiences, but also about how there are many ways to give birth. While women were passionate about homebirth, the message they wanted to convey to others was not primarily about homebirth, but rather, about teaching

women that birth can be an empowering experience if you feel safe and supported throughout the process. Eve said:

I think honestly starts with re-educating women as far as what birth is and what it should be and how it can be done. So much of our natural ability has been stripped from us mentally because we feel like we can't do it anymore because we've been told that, "You do it this way." You go to the hospital.

Homebirth mothers know that their decision to deliver at home is not one that all women will desire or even feel comfortable with—they simply want to others to know that it is a viable option.

After having a homebirth, women became vocally critical of the status quo for birth in the United States, defining it as an approach that strips women of having confidence in their own bodies. As Eve explained:

Most of the women are so in tune with what society teaches them about birthing. It's pretty much a man's job now. It's like, "I'm just gonna hand it over to the doctor." You're just completely stripped from it. But this is what you're born and made to do, have some pride!

Others stressed how empowering birth can be if you, as the mother, are able to feel ownership over the experience. Tami said:

I just think as a woman it's so important to have the birth that you want, even if it doesn't go the way that you want it to go. It's important to be in control of your own body and not to have other people making decisions about your body and your baby and your care. It was a really big deal for me to be able to make those decisions for myself and I would like to empower other women to make those choices, even if it is in a hospital.

Because many women in this study defined the hospital as a place where women struggle to make their own decisions during labor, they felt it was important to make other women aware that birth can be an empowering experience if you are able to make your voice heard and respected in whatever setting you find yourself. Because participants overwhelmingly felt safe and supported in their homebirths, they feel compelled to let other women know that there are alternatives to the hospital.

Yet in situations where women struggled to find a midwife and perhaps found a provider who practiced underground or left the state to seek care, talking about one's birth had the potential to endanger their midwife. Women struggled to find a way to contain their enthusiasm about their experiences and the desire to share their birth stories. Sonia said:

I'm always a little bit torn down the middle about whether to talk about it with people. Because part of me wants to be like evangelical about it and be like, "I really wish that women knew that this was an option." And I want to talk about how wonderful it was, and at the same time whenever somebody asks me, "Well who was your midwife?" I *always* get like a red light feeling...But then I always feel like it cuts you in half because you want to *protect* your midwife, and you also want to bring her business.

Some women, like Sonia, struggled with the oppositional goals of talking about homebirth as a viable option and protecting the safety of their care provider. Others talked about how it did not necessarily make sense to talk with women about "birthing options" if they lived in an area that is not served by any homebirth provider.

Awareness of and Commitment towards Changing State Law

Telling one's birth story and talking to others about “normal” labor is a very direct, personal way that women can effect change by sharing their own knowledge of birth with others. In this context, storytelling becomes an activity that is explicitly about empowering women to take ownership over the birth of their children by encouraging them to think critically about the validity of multiple birthing options.

Women expressed varying levels of awareness of state laws prohibiting direct-entry midwifery; which, in turn, affected whether they chose to engage in efforts to effect legislative change. Grassroots activists in Illinois have been trying for thirty years to pass legislation that would make regulations surrounding midwifery less prohibitive. Although the specifics of the proposed bills to legalize DEMs have changed over the years, the intent of these laws has always been, in the eyes of activists, about trying to increase access to midwifery services for birthing women throughout the state by decriminalizing providers.

Not all women I interviewed were aware of the laws governing midwifery in the state and only about half had ever been involved in any sort of formal political activism surrounding homebirth. Women who found a legal midwife were less aware of the precise legal situation around types of providers in their state. Many women, especially those who struggled to find a midwife underground, learned about Illinois midwifery laws as they worked to find a provider. As they struggled, they were faced with the inevitable question of why finding a nearby midwife was so difficult. This quickly led them to an understanding of the relationship between legal restrictions on

midwives and provider availability in their area.

The degree to which women struggled to find a provider had a direct impact on how aware they were of laws surrounding direct-entry midwifery, but it did not necessarily correspond with how politically engaged women became in midwifery politics. Whether and how a woman chose to engage the legislative process depended on many individual factors. Women varied in their beliefs as to why state law prohibits the practice of DEMs—some women believed that law makers simply are not aware of the documented benefits of homebirth midwifery care for low-risk women; others believed that there is not enough grassroots pressure to force lawmakers into changing regulations; others saw the legislative system as broken and corrupt, having little faith in the ability of individuals to create change on this level. Women navigated these perceptions in some way as they decided whether to become politically active.

Becoming politically active can mean a variety of different things—from calling one's senator or representative, to organizing or attending local advocacy and fundraising events, to going to the state capitol for hearings. But above all, it involves perseverance. These efforts have been underway for years and there is a core group of dedicated women who have continued to call, to organize, to fundraise, and to travel to the capitol. For each woman who has committed to changing midwifery regulations in the state, there are others who either never get involved, or fall out of political engagement as frustration and practical barriers combine. As Marjorie described it:

When I first moved here I was on the email list and I was trying really hard to get people to sign letters and to get politically engaged. Unfortunately I haven't been able to keep up with it. I mean I try to educate people and whenever anybody brings up birth stories or anything I always try to share with people that there are other options. The education is really key, knowledge is power.

Mothers are busy people—aside from taking care of their children, many of them either work outside the home or go to school as well. Being engaged means repeatedly calling, organizing, and visiting lawmakers. Not only is this difficult given the busy nature of women's lives and the multiple commitments they make on a daily basis, but it also requires women to believe that they are at some level able to enact change.

Memories of past legislative efforts can be discouraging. Women who had at some point tried to work toward changing legislation often described it as intimidating:

Grace: What has your experience been working with trying to pass through legislation and involving yourself in politics?

Mavis: It's been intimidating. Our legislator doesn't return phone calls and he doesn't return emails. The first time I talked to him about the Homebirth Safety Act I went down to Springfield and he just had a very stand-offish body posture and just said, "Well why would anybody want to homebirth?" He kept asking that over and over again. He clearly didn't want any information on why it's safe and why we needed legislation to give women the option for homebirth. He didn't get the fact that homebirths are already happening.

Others spoke directly to the disadvantage they felt in trying to find and

Speak with their representative. Sonia said:

It was very laborious to go and hunt him [her state representative] down. Because the state building is huge and there's a billion lobbyists and people standing outside of the chamber rooms. There are back doors to the chamber room and so if the senators or representatives don't feel like talking to you they can just go out the back and then you have to go around the building again and try to catch them at their office. I mean it really feels like it's just a cat and mouse game. They're trying to avoid you at any cost and you're trying to find them. You're at the disadvantage because you're toting some kids and a picnic lunch around (laughs).

It is frustrating for women when they do not see tangible change after they have made the effort to try to talk with and convince their elected officials to vote for licensing bills.

Very few women who contacted their elected official felt that the experience was a positive one. Those who felt as though they had made a difference through this type of activity were both surprised and excited. As Amy described it:

A group of us have gone in quite a few times. I remember the first time I went there was like five or six moms, some of us with little nursing babies...and he was very open and listened to our concerns...it was a very exciting experience to know, "Wow, I just had a direct influence on this man's vote on the issue!" And there are lots of families that are willing to go and talk to legislators but ultimately do we have enough numbers of families to convince legislators? We're not ACOG or the AMA, we don't have millions of dollars to spend on the issue. So it's difficult.

If women did not feel that their elected official was willing to speak with them and

take their legislative concerns seriously, they were less likely to feel empowered to continue pressing for political change.

In this chapter, I have discussed several themes that arise when women decide to give birth at home in an illegal state. First, women reflect upon past birth experiences—both their own, and those of family and friends—before they make the initial decision to plan a homebirth (see figure A).

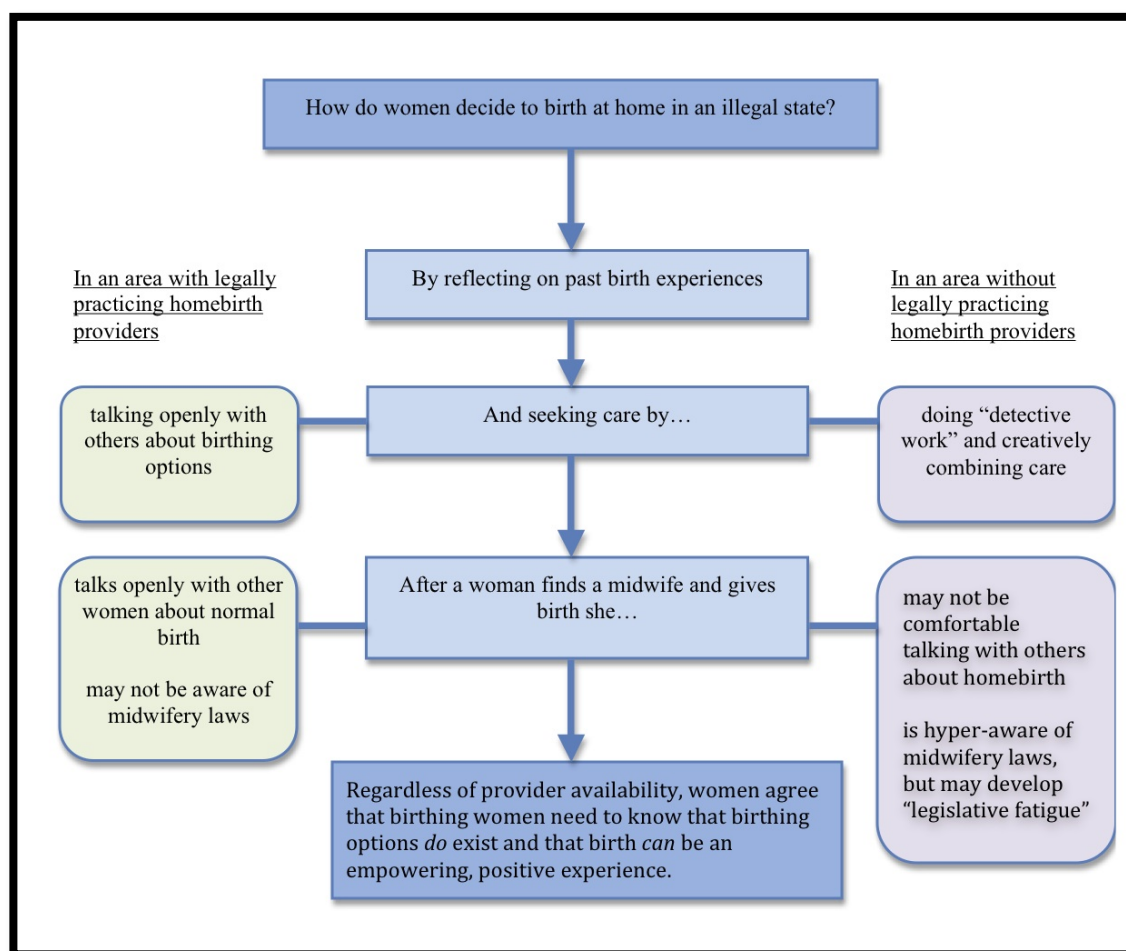


Figure A

Other women's birth stories play an integral role in this process. During this period of

reflection, participants develop a critique of the technocratic model of birth in hospitals. They also articulated the value of autonomous decision-making, voicing a common desire to be able to make health-related decisions during pregnancy and labor and to trust that their provider would respect such decisions.

Next, women engage in the process of seeking care. Significant differences emerge depending on whether a woman is able to access legally practicing providers in her region. In areas where there are no nearby, legally practicing homebirth midwives it is extremely difficult to find information about both homebirth and relevant providers; women who have information to share with mothers searching for care are careful about how and with whom they speak about options because they want to protect their care providers. In contrast, in areas with legally practicing providers, women speak openly about birthing options.

As women seek care, they may encounter barriers related to provider availability, paying out of pocket for care, or being risked out of a homebirth. In areas where there are no legal midwives in practice, women routinely describe lengthy, arduous searches for care. Even in areas with legally practicing midwives, demand outweighs supply and women still struggle with issues of availability. Regardless of the legal status of one's midwife, women actively combine biomedical tools with midwifery care. However, women working without a legally practicing midwife experience variable degrees of success in combining care.

After birthing at home, mothers advocate for change in their region, working to

increase the options available to birthing women as well as a general awareness of alternatives to routine hospital birth. The two primary ways women advocate for change are by speaking from their own birth experience to other women about birthing options and by engaging the legislative process. Women who used legally practicing midwives were overall less aware of state laws restricting midwifery. Women who used underground midwives were more aware of such laws, and thus more likely to advocate for formal political change. Among this group, women often developed a sort of “legislative fatigue” as efforts to change the law moved slowly through congress.

In the next chapter, I integrate these results with the theoretical perspectives outlined in Chapter Three. Based on this analysis, I also provide specific recommendations for future research and for creating a more inclusive maternity care system in the state of Illinois.

Chapter Six: Discussion, Recommendations, and Conclusions

The individual body should be seen as the most immediate, the proximate terrain where social truths and social contradictions are played out, as well as a locus of personal and social resistance, creativity, and struggle. (Scheper-Hughes and Locke, 1987: 31)

In this study I use women's narratives of decision-making as a base from which to contextualize and understand the embodied experience of homebirth in an illegal state (Kleinman 1989, Nelson 2000). Collectively, participants' narratives show how women negotiate multiple barriers to choice as they advocate for an integrated model of maternity care that combines the tools of biomedicine with home-based midwifery care. In this chapter, I use Scheper-Hughes and Locke's (1987) concepts of the body-self, the social body, and the body politic as analytical tools for describing the multiple and often-contested identities women negotiate as they choose, seek and engage in the socially-sanctioned process of delivering their babies at home.

While other studies have looking at integrating multiple models of birth in maternity care systems from the perspective of providers and/or social scientists (Cheyney and Everson 2009; Cheyney 2010; Davis-Floyd 2001; Davis-Floyd and Johnson Eds. 2006; Jordan 1978), very little research has examined what homebirth mothers want in terms of access to multiple models of birth. My finding—that women who choose homebirth often also want to be able to combine models of care—aligns itself with other research that shows the ways in which women pragmatically and selectively use medical technologies as they seek healthcare both in the United States

and abroad (Browner and Preloran 2004; Donner 2003; Hunter 2002; Lock and Kaufert 1998; Makhoul Obermeyer 2000; Rapp 2000; VanHollen 2003).

The decision making processes that women go through when they birth at home in an illegal state is illuminated by a three bodies approach to health and well-being, especially, I would argue, in a political-economic discourse that tries to fit women's decisions within the confines of the reductionist debate over the safety of homebirth itself. By trying to fit women's decision to birth at home into a dichotomous political debate over homebirth as safe vs. unsafe, the nuances of women's voices and concerns do not often rise to the forefront of public discussions of birth in Illinois.

As illustrated in the grounded theory schema (Figure A) found in chapter five, when women decide to birth at home in an illegal state, they move through three major processes—1) reflecting on past birth experiences, 2) seeking care, and 3) advocating for change. Each of these steps corresponds with one of the “three bodies” put forth by Scheper-Hughes and Locke (1987). When women make the initial decision to stay home, they act largely within the body-self by reflecting on the lived, embodied experience of birth. As women begin to seek care, they move into the social body—talking with friends and family about the decision, looking for a midwife, and encountering homebirth as it relates to the social norm of birth in a hospital setting. Finally, as women advocate for change, they are looking for direct, meaningful ways to engage the body politic. The body-self, the social body, and the body politic are all

in constant interplay, making it impossible to neatly separate them, and the same is true for the three themes I have identified. Nonetheless, as women move through the chronological process of decision making, they narrate their roles as birthing women in ways that shift fluidly between these three levels of self-hood, becoming increasingly inclined toward creating social and political change in birthing norms.

Scheper-Hughes and Lock (1987) describe the body-self as an individual, a body that is aware both of itself and of its separation from other bodies. The authors stress that, in Western thought, the body-self is intertwined with the Cartesian idea that the mind and the body are inherently separate and opposed to one another. This separation is so ingrained, they argue, that we lack a common vocabulary with which to speak about phenomena that transcend this dichotomy. As women in this study made the initial decision to birth at home through learning from past experiences of birth, they developed an implicit critique of this mind-body dualism. In doing this, they create and also advocate for a more holistic model of care.

As women reflected on birth as they and their friends and family had lived it, two major subthemes arose. These subthemes—critiquing the technocratic model of birth and valuing autonomous decision-making—have at their heart a rejection of the mind/body dualism. Women wanted socially supportive care that valued both one's physical well-being and a woman's autonomy in labor. Scheper-Hughes and Lock explain that the body-self is not seen through an individualistic, mind/body lens in all culture. In this case, women's decisions exemplify a concept of the body-self in which

one's "physical" and "mental" needs become complementary and inseparable.

As women seek care their main concerns shift from the realm of the body-self to the social body. As women search for a midwife, try to combine care from multiple types of providers, and talk with family and friends about their decision to birth at home, their individual decisions take on a social dimension. Scheper-Hughes and Lock describe the social body as symbolic of the nature of society (1987:20). While in many cultures individual illnesses become indicative of societal conflict or disharmony, in the United States, individual bodies are seen as separate from the social and natural worlds. Metaphors of the birthing body as a machine are hegemonic in industrialized cultures (Davis-Floyd 1992; Martin 1987). Scheper-Hughes and Lock argue that these metaphors illustrate the key values of capitalist production, which consider both human labor and natural resources to exist for the sole purpose of producing commodities. In engaging others in the decision to birth at home, women reject powerful metaphors of the technocratic birthing body, and in doing so, often become the targets of judgment and social stigma.

In challenging the technocratic model of birth, participants in this study identified bodily metaphors in a hospital labor and delivery ward such as being on an assembly line or birthing "by the clock," even if they themselves had never birthed in a hospital setting. In the conversations women have with others as they struggle to find and combine midwifery care with biomedical models, conflict arises between two very different ways of knowing about the birthing body. As women seek mutual

accommodation between types of care, they are navigating very different notions of what the body is and how it should be treated. These conversations do not take place in a power vacuum; they exist in relation to and are shaped by the social body as well as the body politic.

The body politic, the third of the three bodies, deals directly with issues of power and control as individuals negotiate their identities within the three bodies. In the chronology of decision-making, the body politic most closely corresponds with the theme of advocating for change. After women have given birth at home, many want to change the way the state regulates and controls birth in the United States. They usually attempt do so by talking to other women about the existence of alternatives to a technocratic model of birth and/or by engaging in political activism to designed to overturn restrictive, anti-midwifery legislation.

In this study, the body politic can be seen both from the perspective of mothers advocating for change and from the perspective of those who fight to maintain the dominant paradigm. Scheper-Hughes and Lock argue that: “when the sense of social order is threatened... boundaries between the individual and body politic become intensified along with those of social control” (1987:24). In choosing to birth at home, women are rejecting some of the key tenets of Western notions of the body—the Cartesian mind/body split and the individualistic body-as-machine metaphor. Thus, homebirth threatens the social order; this goes a long way to explaining why the last 30 years of grassroots activism that has been trying to decriminalize homebirth

midwifery in Illinois has been so unsuccessful.

With its focus on power relations and bodily control—both of individuals and of populations—the concept of the body politic aligns well with some of the key tenets of critical medical anthropology (CMA) and feminist bioethics. Both of these approaches encourage us to think critically about the cultural and socio-political contexts of decision-making and the dynamics of health and well-being. They also advocate for research and interventions that take an ethical and political stance by working explicitly toward understanding and changing oppressive power relationships.

CMA also brings to light the marginalized position of homebirth in the context of the U.S for-profit, maternity care system. Although it is generally less expensive to birth at home than it is in a hospital—it is extremely difficult and at times impossible to receive insurance reimbursement for homebirth services, especially if one's midwife is not a legally-recognized provider. This lack of institutionalized support for homebirth stratifies the population that is able to seek in-home maternity care, making it much more difficult for women of lower-socioeconomic status (who in this country are also disproportionately women of color) to make the choice to birth at home. Of the women in this study who struggled to afford the cost of homebirth care, all strategized to find creative ways of overcoming this barrier. These included getting a cash-advance on a credit card, working out a payment plan, having an unassisted birth, or going to the hospital to attempt a “natural” delivery.

As women decide to have a homebirth in an illegal state, seek care, then

advocate for changing birthing norms, they simultaneously negotiate the body-self, the social body, and the body politic. Together these overlapping identities shape how women make decisions and, ultimately the political and economic environment where they seek care. While homebirth mothers in Illinois are trying to make homebirth something that other women know about and can explore as an option, even in this, they are constrained by powerful structures—both of Western conceptions of the body and of formal policymaking.

Based on the findings from this study, I advocate a restructuring of the current homebirth debate in the United States. We need to move away from the debate over safety and move toward one based on the holistic needs and experiences of mothers. In the current debate over homebirth in the state of Illinois, the terms are set by an authoritative system of knowledge that sees birth as an inherently dangerous process that should only take place in a hospital setting. The women who participated in this study do not see homebirth as inherently dangerous. Rather than debating safety, women express an alternative and wide range of concerns. First, they want midwives to be able practice without the fear of persecution so that there will be a greater availability of skilled providers. Second, they want to increase a general awareness of homebirth as a viable option for low-risk women. And finally, they want to be able to make their own decisions about how, where, and with whom to give birth.

In order to create an integrated maternity care system that meets the needs of a diversity of women and birthing families, there needs to be a forum where the voices

of homebirth mothers and others with critiques of the dominant paradigm can be heard. Women are not going to feel empowered to speak unless they have some faith that those they speak to are going to listen and, if the listener does not agree with their point of view, withhold judgment. This goes for any setting—the hospital, calling representatives, telling friends and families, etc.

What women in my sample wanted was not simply to have a greater availability of midwives who could practice without the fear of prosecution. What women are most critical of is the authoritative nature of the way our culture knows about birth. Because homebirth mothers are speaking from outside this authoritative way of knowing, their voices are easily marginalized and silenced at multiple levels.

This process of silencing has unintended consequences. It creates a system that is not reflective of mothers' needs and priorities. The women in this study know what is important to them and make decisions accordingly, even in a political-economic environment like Illinois, where their choices are extremely limited. Ultimately, it is mothers, not doctors, not nurses, not insurance companies, not family members, who live the consequences of their decisions. By not listening to their concerns and values, a system has emerged that makes it more difficult and more dangerous for women to birth at home. The relevant question is not whether women will birth at home. They will. The relevant question is whether to create a safe, supportive environment for birthing women, even if their decisions do not align with dominant beliefs surrounding birth.

In conclusion, this study is an attempt, grounded in women's narratives, to understand how mothers decide to give birth at home in a state that does not recognize birth at home with a DEM as a legal option. I argue that not only is it necessary to put the narratives of birthing women at the heart of studies on decision-making in birth, but also that it is necessary to make explicit the unequal relations of power that maintain the current obstetric- and hospital-dominated maternity care system in the United States.

Any attempt to improve maternal-child health needs to put the voices of birthing women at its center, for they are the ones whose lives systems ultimately effect. This seems like commonsense wisdom, but after interviewing women about how they decided to have a homebirth in a state where it is often extremely difficult to do so I have come to think of listening to birthing women as a revolutionary and much needed practice.

How can we as a society speak for the best interests of mothers and babies if we do not ask mothers what they want and need to feel supported? Without explicitly asking this question, and truly listening to the answers women give, we run the risk of making decisions according to authoritative and one-sided views of what birth should look like. Without explicitly asking this question, creating a system where different ways of knowing about and performing birth support one another simply cannot emerge.

Finally, I want to conclude by pondering why the mutual accommodation

called for by Jordan so long ago between homebirth midwifery and obstetrics has yet to be achieved. It has been over thirty years since her initial call and over thirty years since grassroots advocates began to advocate for decriminalizing DEMs through state licensure in Illinois. Part of the slow pace relates to the idea that women who birth at home challenge the social order by questioning fundamental Western notions of the body. Part of the slow pace also relates to the gaping power inequality between midwifery advocates and those opposed to legislation that would legalize direct-entry midwifery. By setting the terms of the debate as one over safety, parties opposed to homebirth midwifery have effectively redirected public attention away from the needs and desires of birthing women.

The narratives of homebirth mothers show a strong commitment toward normalizing birth and a strong desire to have obstetric and midwifery care support one another. Only by putting the experiences and desires of birthing women at the forefront of maternity care reform debates can we hope to create more inclusive, safe, and empowering approaches to childbirth in the United States.

Bibliography

- Adams, V., Miller, S., Chertow, J., Craig, S., Samen, A., & Varner M. (2005). Having a "Safe Delivery": Conflicting Views from Tibet. *Health Care for Women International* 26, 21-851.
- American College of Nurse Midwives. (2005). *Position Statement on Home Birth*. Washington, D.C: American College of Nurse Midwives.
- American College of Obstetricians and Gynecologists. (2007). *ACOG Statement of Policy as Issued by the ACOG Executive Board: Home Births in the United States*. Washington, D.C: American College of Obstetricians and Gynecologists.
- American Medical Association. (2008). *Home Deliveries*. (Resolution:205 A-08).
- American Public Health Association. (2001). *Increasing Access to Out-of-Hospital Maternity Care Services through State-Regulated and Nationally-Certified Direct-Entry Midwives*. (APHA Policy Statement #20013).
- Baer, H., Singer, M., & Susser, I. (Eds.). (2003). *Medical Anthropology and the World System*. Westport: Prager Publishers.
- Bernard, R.H. (2006). *Research Methods in Anthropology: Qualitative and Quantitative Approaches*. Lanham: Altamira Press.
- Berry, N. (2006). Kaqchikel Midwives, Home Births, and Emergency Obstetric Referrals in Guatemala: Contextualizing the Choice to Stay at Home. *Social Science and Medicine* 62, 1958-1969.
- Boucher, C., Bennett, C., McFarlin, B., & Freeze, R. (2009). Staying Home: Why Women in the United States Choose Home Birth. *Journal of Midwifery and Women's Health* 54(2):119-126.
- Browner, C.H., and Preloran, H.M. (1996). The Production of Authoritative Knowledge in American Prenatal Care. *Medical Anthropology Quarterly* 10(2):141-156.
- Browner, C.H., and Preloran, H.M. (2004). Expectations, Emotions, and Medical Decision-Making: A Case Study on the Use of Amniocentesis. *Transcultural Psychiatry* 41(4):427-444.
- Charmaz, K. (2006). *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis*. Thousand Oaks: SAGE Publishing.
- Cheyney, M. (2005). In Transition: *A Biocultural Analysis of Homebirth Midwifery in the United States*. Unpublished Doctoral Dissertation. Eugene: University of Oregon.
- Cheyney, M. (2008). Homebirth as Systems-Challenging Praxis: Knowledge, Power, and Intimacy in the Birthplace. *Qualitative Health Research*, 18, 251-267.
- Cheyney, M. (2010). *Born at Home: The Biological, Cultural, and Political Dimensions of Maternity Care in the United States*. Florence: Cengage Learning.
- Cheyney, M. and Everson, C.E. (2009). Narratives of Risk: Speaking across the

- Hospital/Homebirth Divide. *Anthropology Newsletter* March 7-9.
- Clarke, A.E. (2003). Situational Analyses: Grounded Theory Mapping After the Postmodern Turn. *Symbolic Interaction* 26: 553-576.
- Craven, C. (2007). A "Consumer's Right" to Choose a Midwife: Shifting Meanings for Reproductive Rights Under Neoliberalism. *American Anthropologist* 109(4): 701-712.
- Dahlen, H.G., Barclay, L.M., & Homer, C.S.E. (2010). The Novice Birthing: Theorising First-Time Mothers' Experiences of Birth at Home and in Hospital in Australia. *Midwifery* 26:53-63.
- Davis-Floyd, R. (1992). *Birth as an American Rite of Passage*. Berkeley: University of California Press.
- Davis-Floyd, R. (1998). The Ups, Downs, and Interlinkages of Nurse- and Direct-Entry Midwifery: Status, Practice, and Education. In *Pathways to Becoming a Midwife: Getting an Education*. Eugene: Midwifery Today.
- Davis-Floyd, R. (2001). The Technocratic, Humanistic, and Holistic Paradigms of Childbirth. *International Journal of Gynecology and Obstetrics*, 75, S5-S23.
- Davis-Floyd, R. and Johnson, C.B. (Eds.). (2006). *Mainstreaming Midwives: The Politics of Change*. New York: Routledge.
- Donchin, A. (2009). Feminist Bioethics. *The Stanford Encyclopedia of Philosophy* Zalta, E.N. (Ed.). Retrieved from: [ord.edu/archives/sum2009 / entries/feminist-bioethics/](http://plato.stanford.edu/archives/sum2009/entries/feminist-bioethics/).
- Donner, H. (2003). Place of Birth: Childbearing and Kinship in Calcutta Middle-Class Families. *Medical Anthropology*, 22, 303-341.
- Ellis, C. (2003). Foucault, Feminism, and Informed Choice. *Journal of Medical Humanities* 24(3): 213-228.
- Farmer, P. (2004). An Anthropology of Structural Violence. *Current Anthropology* 5(3):305-325.
- Foucault, M. (1977). *Discipline and Punish: The Birth of the Modern Prison System*. New York: Vintage Books.
- Fraser, G. (1998). *African-American Midwifery in the South: Dialogues of Birth, Race, and Memory*. Boston: Harvard University Press.
- Ginsburg, F. and Rapp, R. (Eds.). (1995). *Conceiving the New World Order: The Global Politics of Reproduction*. Berkeley: University of California Press.
- Horlick-Jones, T. & Prades, A. (2009). On Interpretative Risk Perception Research: Some Reflections on Its Origins; Its Nature; and Its Possible Applications in Risk Communication Practice. *Health, Risk, & Society* 11(5):409-430.
- Horton, S. & Lamphere, L. (2006). A Call to an Anthropology of Health Policy. *Anthropology Today*. Retrieved from <http://www.aaanet.org/press/an/0106/horton.html>.
- Hunter, C.L. (2002). Embracing Modernity: Transformations in Sasak Confinement Practices. In *Daughters of Hariti: Childbirth and Female Healers in South and Southeast Asia*. Rozario S and Samuel G (Eds.). Pp. 279-297. New York:

Routledge.

- Janssen, P.A., Henderson, A.D., & Vedam, S. (2009). The Experience of Planned Home Birth: Views from the First 500 Women. *Birth: Issues in Perinatal Care* 36(4):297-304.
- Janssen, P.A., Lee, S.K., Ryan, E.M., Etches, D.J., Farquharson, D.F., Peacock, D., & Klein, M.C. (2002). Outcomes of Planned Home Births Versus Planned Hospital Births After Regulation of Midwifery in British Columbia. *CMAJ* 116:315-323.
- Jenkins, G.L. (2003). Burning Bridges: Policy, Practice, and the Destruction of Midwifery in Rural Costa Rica. *Social Science and Medicine*, 56,1893-1909.
- Johnson, K.C., & Daviss, B.A. (2005). Outcomes of Planned Home Births with Certified Professional Midwives: Large Prospective Study in North America. *British Medical Journal* 330:1416-1419.
- Jordan, B. (1978). *Birth in Four Cultures: A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden, and the United States*. Montreal: Eden Press.
- Jordan, B. (1997). Authoritative Knowledge and Its Construction. In *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives*. Davis-Floyd, R. and Sargent, C. (Eds.). Pp. 55-80. Berkeley: University of California Press.
- Kaufert, P.A., & O'Neil, J.D. (1990). Co-option and Control: The Reconstruction of Inuit Birth. *Medical Anthropology Quarterly* 4(4):427-442.
- Kleinman, A. (1989). *The Illness Narratives: Suffering, Healing and the Human Condition*. United States: Basic Books.
- Kornelsen, J., Kotaska, A., Waterfall, P., Willie, L., & Wilson, D. (2010). The Geography of Belonging: The Experience of Birthing At Home for First Nations Women. *Health & Place* 16(4):638-645.
- Klassen, P.E. (2001). Sacred Maternities and Postbiomedical Bodies: Religion and Nature in Contemporary Home Birth. *Signs: Women in Culture and Society*, 26(3),775-809.
- Kyomuhendo, G.B. (2003). Low use of rural maternity services in Uganda: Women's Status, Traditional Beliefs and Limited Resources. *Reproductive Health Matters* 11(21), 16–26.
- Lindgren, H., Hildingsson, I., & Radestad, I. (2006). A Swedish Interview Study: Parents' Assessment of Risks in Home Births. *Midwifery* 22:15-22.
- Lock, M. & Kaufert, P.A. (Eds.). (1998). *Pragmatic Women and Body Politics*. Cambridge: University of Cambridge Press.
- MacDonald, M. (2006). Gender Expectations: Natural Bodies and Natural Births in the New Midwifery in Canada. *Medical Anthropology Quarterly* 20(2), 2 256.
- MacDorman, M., Menacker, F., & Declercq, E. (2010). Trends and Characteristics of Home and Other Out-of Hospital Births in the United States, 1990-2006. *National Vital Statistics Reports*, (58)11, Hyattsville: National Center for Health Statistics.

- Makhlouf Obermeyer, C. (2000). Pluralism and Pragmatism: Knowledge and Practice of Birth in Morocco. *Medical Anthropology Quarterly* 14(2):180-201.
- Martin, E. (1987). *The Woman in the Body: A Cultural Analysis of Reproduction*. Boston: Beacon Press.
- Midwives Alliance of North America. (2010). *Position Statements*. Washington, D.C.: Midwives Alliance of North America. Retrieved from: <http://mana.org/positions.html>.
- Mykhaloskiy, E. (2008). Beyond Decision Making: Class, Community Organizations, and the Healthwork of People Living with HIV/AIDS. Contributions from Institutional Ethnographic Research. *Medical Anthropology* 27(2): 136-163.
- Nelson, H.L. (2000). Feminist Bioethics: Where We've Been, Where We're Going. *Metaphilosophy* 31(5):492-508.
- Olsen, O. (1997). Meta-Analysis of the Safety of Homebirth. *Birth* 24:4-13.
- Otis, K.E. & Brett, J.A. (2008). Barriers to Hospital Births: Why do Many Bolivian Women Give Birth at Home? *Pan-American Journal of Public Health* 24(1):46-53.
- Pfeiffer, J. & Nichter, M. (2008). What Can Critical Medical Anthropology Contribute to Global Health? *Medical Anthropology Quarterly* 22(4):410-415.
- Possamai-Inesedy, A. (2006). Confining Risk: Choice and Responsibility in Childbirth in a Risk Society. *Health Sociology Review* 15(4): 406-506.
- Rapp, R. (2001). Gender, Body, Biomedicine: How Some Feminist Concerns Dragged Reproduction to the Center of Social Theory. *Medical Anthropology Quarterly*, 15(4), 466-477.
- Rapp, R. (2000). *Testing Women, Testing the Fetus: The Social Impact of Amniocentesis in America*. New York: Routledge.
- Rooks, J.P. (1997) Safety of Out-of-Hospital Births in the United States. In *Midwifery and Childbirth in America* Pp. 345-384. Philadelphia: Temple University Press.
- Root, R. and Browner, C.H. (2001). Practices of the Pregnant Self: Compliance With and Resistance To Prenatal Norms. *Culture, Medicine, and Psychiatry* 25: 195-223.
- Scheper-Hughes, N. (1990). Three Propositions for a Critically-Applied Medical Anthropology. *Social Science and Medicine* 30(2):189-197.
- Scheper-Hughes, N. and Lock, M. (1987). The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology. *Medical Anthropology Quarterly* 1:6-41.
- Seear, K. (2009). 'Nobody Really Knows What It Is or How to Treat It': Why Women with Endometriosis Do Not Comply with Healthcare Advice. *Health, Risk, & Society* 11(4): 367-385.
- Singer, M. (1995). Beyond the Ivory Tower: Critical Praxis in Medical Anthropology.

- Medical Anthropology Quarterly* (9)1: 80-106.
- Spencer Freeze, R.A. (2008) Born Free: Unassisted Childbirth in North America. Unpublished PhD Dissertation: University of Iowa.
- The Big Push for Midwives. (2010). *2010: State-by-State Status of Certified Professional Midwives (CPMs)*. Retrieved from <http://www.thebigpushformidwives.org/index.cfm/fuseaction/home.stateStatus/index.htm>.
- Thompson, C.J. (2005). Consumer Risk Perceptions in a Community of Reflexive Doubt. *Journal of Consumer Research* 32: 235-248.
- Van Hollen, C. (2003). *Birth on the Threshold: Childbirth and Modernity in South India*. Berkeley: University of California Press.
- Viisainen, K. (2000). The Moral Dangers of Home Birth Parents' Perceptions of Risks in Home Birth in Finland. *Sociology of Health and Illness* 22(6): 810-814
- Viisainen, K. (2001). Negotiating Control and Meaning: Home Birth as a Self-Constructed Choice in Finland. *Social Science and Medicine* 52(7):1109-1121.
- World Health Organization. (1996). *Care in Normal Birth: A Practical Guide*. Geneva: Department of Reproductive Health and Research. Retrieved from http://whqlibdoc.who.int/hq/1996/WHO_FRH_MSM_96.24.pdf.